Alameda County Public Health Department Starting Out Strong Family Support Programs

Support for pregnant women, mothers, fathers and families with young children

CONFIDENTIAL REFERRAL FORM

For all referrals, fax to 510-618-1973. Questions? Call Yael Martinez at 510-618-1914 or email HomeVisiting@acgov.org

PLEASE ATTACH ANY RELEVANT INFORMATION

Date _____ Name of Referring Provider _____ Referring Agency _____

Referring Provider Contact Information: Phone _____ Email _____ Fax _____

Has the Provider talked about this referral with potential client? ☐ Yes ☐ No

Type of Services Desired _____

Reason for Referral by Provider _____

Client is (check all that apply): ☐ **Pregnant Individual** ☐ **Parent with fetal/infant loss** ☐ **Mother** ☐ **Father** ☐ **Postpartum Person (6-8 weeks after birth)** ☐ **Other:** _____

Section 1: Parent/Adult Information

First Name _____ Last Name _____ Email address _____

Address _____ City _____ Zip _____ Insurance _____

DOB _____ Cell _____ Race/Ethnicity _____ Languages spoken _____

Emergency Contact Name _____ Tel _____ Cell _____

Does Client Identify as ☐ Female ☐ Male ☐ Transgender ☐ Gender Nonbinary ☐ Specify: _____

Psychosocial/Medical Information _____

Section 2: Pregnancy Information for referrals that are or have been pregnant in the past:

Gravida (#pregnancies) _____ Para (#live births) _____ # of pregnancy losses _____ ☐ Hx of Infant Loss Date _____

Section 3: Is person you are referring pregnant now? ☐ Yes ☐ No **If not, skip to section 4.**

OB Provider Name _____ OB Phone Contact _____

Gestational Age _____ Expected Date of Delivery _____ OB Email _____

☐ First Trimester (1-12 wks) ☐ Second Trimester (13-27 wks) _____ ☐ Third Trimester (28-40 wks) _____

Prenatal Information _____

Section 4: Infant/Child/Family Information ☐ Check if parent gave birth in the last 8 weeks

Child's Name _____ Child's DOB _____ Child's Birthweight _____

Family Information _____

_____

Psychosocial/Medical Information _____

Pediatric Provider Name _____ Pediatric Provider Email/Phone: _____

For ACPHD Use Date Referral Received _____ Date Referral Given to Program _____

Referred to: ❑BIH ❑BB ❑BCHO-SpSt ❑DREAMS ❑Fatherhood ❑HFA ❑EmbraceHer ❑MPCAH SpSt ❑NAHC SFTHV ❑NFP ❑OEHS ❑TVHC

Referral Source Contacted ❑Yes ❑No Date _____ By _____