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 Elka Jones at 510-667-4333 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 ____________________ Date of birth ____________________

Address ______________________________ Unit ________ City ______________________ Zip __________

Tel __________ Cell __________ Ethnicity __________ Languages spoken __________ Insurance __________

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: __________

Prenatal Information: ____

Section 3: Is adult 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) ________

Section 4: Infant/Child/Family Information

☐ Check if parent gave birth in the last 8 weeks ☐ Hx of Infant Loss Date: ______________________________

Child's Name: ________________________ Child's DOB: ______________ Child's birthweight

Pediatric Provider Name: ________________ Pediatric Provider Email/Phone: ____________________

Psychosocial/Medical Information: ____

Family Information: ____

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 ______________________________