

Prenatal & Early Years Home Visiting Program Referral Form

PLEASE FAX THIS REFERRAL TO: (250) 674-2676

Client's Name: _____

Address: _____

Telephone: _____ Birth date: _____

If Pregnant - Due Date: _____ AND/OR

Children's Name(s) & Ages:

Client aware of referral: YES NO

Check only items that you have knowledge of:

_____ Unstable Housing/Food Security _____
_____ Unplanned Pregnancy _____
_____ Lack of Partner, Family and/or Social Supports _____
_____ Family Crisis or Violence _____
_____ Literacy Concerns _____
_____ Physically and/or Mentally Challenged _____
_____ Mental Health Concerns (including post-partum depression) _____
_____ Alcohol/Drug use _____
_____ Smoking _____
_____ Other _____

Are there any safety or health concerns that our staff should be aware of? If yes, please explain:

History and additional information if relevant:

Referred by: _____ Date of referral: _____

(Please print)

Relationship of referral source to client: _____

Signature of referral source: _____