YELLOWHEAD
COMMUNITY SERVICES

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: _____

CLEARWATER
612 Park Drive, Clearwater, BC V0E 1N1
Telephone: 250-674-2600 Facsimile: 250-674-2676

BARRIERE
4936 Barriere Town Road, Barriere BC V0E 1E0
Telephone: 250-672-9773 Facsimile: 250-672-9709