Healthy Families
Referral Form

501 East Fayette Street Syracuse, NY 13202
Phone: 435-2000 Fax: 435-5033
www.onhealthyfamilies.com

Client Last Name:_____ First Name:_____ DOB:_____

Address: _____

Apt #: _____ City:_____ Zip Code: _____

Phone#:_____ Alternate #: _____ Language: _____

Name of Doctor_____ ☐ No Doctor

Insurance information: ☐ No insurance
☐ Private insurance and name_____
☐ Medicaid and number _____ ☐ Other: _____

Please check all that apply: Are you?
☐ Pregnant- **Due date**_____ Pregnant with your first child? ☐ Yes ☐ No
☐ Parenting (infant/child under two years of age)

Please list the infant/child being referred:

Child's name: _____ DOB: _____ Sex: ☐ M ☐ F

Your Child's Doctor's Name: _____

Please check what you would like help with and/or more information on:
☐ **Pregnancy-** what to expect, getting ready to have a baby, labor and delivery
☐ **After delivery-** what to expect after the baby, family planning, birth control
☐ **Infant care-** bathing, feeding, what to expect as they grow and develop
☐ **Breastfeeding-** how to breastfeed, questions about breastfeeding, support and resources
☐ **Parenting-** child care, potty training, stress, supports and resources
☐ **Grief-** death of my baby, coping, community supports for me and my family
☐ **Depression-** mental health concerns during pregnancy and/or after delivery
☐ **Other -** ☐ WIC ☐ Housing ☐ Finances ☐ Job ☐ Education ☐ Insurance
☐ Food Stamps ☐ Baby supplies, crib, etc ☐ Early Intervention
☐ **Other:**_____

Name of person completing this form: _____ Phone: _____

Referring agency & contact: _____ Date: _____

Is the client aware of referral? ☐ Yes ☐ No

Information below is for office use only

Referral to: ☐ Nursing ☐ CHWP ☐ Social Worker ☐ Nutritionist ☐ WIC ☐ Early Intervention

Referral Source: ☐ CHHA ☐ Community Program (incl. Schools) ☐ EI/PS ☐ Hospital
☐ Local Social Services CPS ☐ Local Soc Services Probation ☐ Medical Provider
☐ Other ☐ Other LHCSA ☐ Self / Family / Friend

Received by: _____ Date: _____