PLEASE PRINT CLEARLY

# Initial Referral Form

* REQUIRED *

*Date of Referral ___ - ___ - ___

## Participant Information

*Last Name _____ *First Name _____ *Date of Birth ___ - ___ - ___

*Street Address _____ *City _____

*Zip Code _____ *County _____ Participant ID _____

***Primary Language** *(Choose one)*
- ○ English
- ○ Spanish
- ○ Other _____

***Race** *(Choose one)*
- ○ Black
- ○ White
- ○ Asian
- ○ Native American
- ○ Multi-Racial
- ○ Alaskan/Pacific Islander
- ○ Other _____

***Ethnicity** Hispanic ○ Yes ○ No

***Health Insurance** *(Select all that apply)*
- ○ Medicaid PE
- ○ Medicaid MC
- ○ NJ Family Care
- ○ Medicare
- ○ Commercial/Private
- ○ Uninsured/Self Pay

## Participant Contact Information

*Primary Phone ___ - ___ - ___

Alternate Phone ___ - ___ - ___

Email Address _____

***Preferred Contact Method** *(Choose one)*
- ○ Primary Phone
- ○ Alternate Phone
- ○ Email
- ○ Text

***At which phone number can we text you?**
- ○ Primary
- ○ Alternate
- ○ None

## Household Information

Married? ○ Yes ○ No

* # of Children in the home ___

Date(s) of birth of children needing services | Name of Child | Relationship

1. ___/___/___ _____ _____
2. ___/___/___ _____ _____
3. ___/___/___ _____ _____

## Participant Is... *(Choose One)*

| ○ Preconceptional Woman | ○ Pregnant Woman | ○ Interconceptional Woman | ○ Male |
|---|---|---|---|
| *Has no children and has never been pregnant.* | * First Time Parent? ○ Yes ○ No<br>* In Prenatal Care? ○ Yes ○ No<br>* Due Date ___ - ___ - ___ | *Previously pregnant and not currently pregnant. (Does not matter if woman has children.)*<br>*First Time Parent? ○ Yes ○ No | * Are you a Parent? ○ Yes ○ No<br>* First Time Parent? ○ Yes ○ No<br>Does your child live w/ you? ○ Yes ○ No |

## Reason for Referral - Household Needs

- ___ Primary care for myself
- ___ Primary care for my children
- ___ Prenatal care
- ___ Public benefits
- ___ In-home parent support (home visiting)
- ___ Assistance connecting to services (CHW)
- ___ Group parent support
- ___ Recovery Support Services
- ___ Other _____

## Referral Agency Information

*Referral Agency Name _____

Name of Person Making the Referral _____ Phone ___ - ___ - ___

Email Address _____ Phone Extension _____

## Comments

## Program Use Only

Date Pregnancy Test Given ___ - ___ - ___

Pregnancy Test Positive? ○ Yes ○ No

Outreach Type
- ○ Agency
- ○ Door to Door
- ○ Self
- ○ Event *(Specify)* _____

* Participant Consent

I agree to have the information I provided for this initial referral shared with the Central Intake hub for my county. I agree to be contacted by Central Intake staff, who will further assist with connecting me and/or my family to supportive services.

○ Oral consent given

Signature of Participant

*Sign* _____ *Print* _____

Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

Fax# _____

Rev 092016