

Referral Form

Please complete this referral form to connect families to the **Healthy Families - Family Support Program**. Fill out all sections as completely as possible, including family contact information, reason for referral, and any safety or risk concerns.

Parent(s) Name

Last First MI Date of Birth

Last First MI Date of Birth

Address Primary Contact Number

City State Zip Code County Secondary Contact Number

Primary Doctor/Clinic Parent Email

Y/N Phone Call Text Email

Baby's Name Date of Birth/Due Date Language Spoken in Home Interpreter Preferred Contact Method

Insurance: Private Nebraska Medicaid Nebraska CHIP No Health Insurance Other: _____

Current Barriers/Circumstances in the home (Check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Parent under 21 years old | <input type="checkbox"/> First-time parent | <input type="checkbox"/> Inadequate income (Under 250% federal poverty level) |
| <input type="checkbox"/> History of/current child welfare involvement | <input type="checkbox"/> Unstable Housing | <input type="checkbox"/> Education under 12 years (no HS grad/no GED) |
| <input type="checkbox"/> Limited/no prenatal care | <input type="checkbox"/> Baby born premature/low birth weight | <input type="checkbox"/> History of/current depression |
| <input type="checkbox"/> Tobacco use in the home (any product containing nicotine) | <input type="checkbox"/> Relationship/family stress | <input type="checkbox"/> Exposure to violence in home/community |
| <input type="checkbox"/> Parent/Child has developmental disability | <input type="checkbox"/> History of/current substance use | <input type="checkbox"/> Parent member of armed forces with multiple deployments |

Notes: _____

Referral made by: _____ Date: _____

Agency: _____ Contact: _____

Referrals can be faxed to Southwest Nebraska Public Health District at 308-284-2137 or emailed in secure email to diana@swhealth.ne.gov. If you have any questions, please contact Program Manager, Diana Garcia, at 308-345-4223.

FOR OFFICE USE ONLY

Referral Refused

RECORDED
DATE: _____
INITIALS: _____