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| Referral Criteria: <input type="checkbox"/> Lives in _____ County <input type="checkbox"/> Currently pregnant or with a baby less than 3 months old | | Permission to Contact: <input type="checkbox"/> Family is aware that referral is being made <input type="checkbox"/> Date mom/dad was spoken with about the program _____ | |
| Referral Source Information | | | |
| Name: | | Phone: | |
| Agency/Institution Name: | | Referral Date: | |
| Parent Information | | | |
| Mom's Name: | | Dad's Name: | |
| Mom's Address: | | Dad's Address: | |
| City: | Zip Code: | City: | Zip Code: |
| Birth Date: | <input type="checkbox"/> English <input type="checkbox"/> Spanish | Birth Date: | <input type="checkbox"/> English <input type="checkbox"/> Spanish |
| Mom's phone: | Dad's phone: | Other phone: | |
| Parent preferred contact method (circle): Phone Text: Email: | | | |
| Baby/ Sibling Information | | | |
| Baby's Name: | | Due Date or Birth Date: | |
| Sibling's Name(s): _____ | | Birth Date: _____ | |
| Reason for Referral (Check all that apply) | | | |
| <input type="checkbox"/> Single Parent <input type="checkbox"/> Either Parent Unemployed <input type="checkbox"/> Family with limited Income <input type="checkbox"/> Unstable Housing <input type="checkbox"/> No Phone <input type="checkbox"/> Less than 12th Grade Education <input type="checkbox"/> Limited Support/ Emergency Contacts <input type="checkbox"/> History of Substance Abuse | | <input type="checkbox"/> Late or No Prenatal Care/Poor Compliance <input type="checkbox"/> History of Abortions <input type="checkbox"/> History/Current Depression or Psychiatric Care <input type="checkbox"/> Adoption or Abortion Sought this Pregnancy <input type="checkbox"/> Marital or Family Stresses <input type="checkbox"/> Low Birth Weight Infant (<5 lbs.) <input type="checkbox"/> Special Needs Infant (as diagnosed medically or as perceived by parent) | |
| Other Important Information (CPS Involvement, Pending Discharge Date, Multiple birth, infant(s) in NICU, etc): | | | |
| For Program Use Only | | | |
| Referral reviewed by: _____ | | Referrals/ Services Provided: _____ | |
| Date reviewed: _____ | | _____ | |
| Reason Assessment Not Completed: _____ | | _____ | |
| Deposition of Offer of Services: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | | _____ | |
| Reason for Declination: | | _____ | |
| Date Contacted Referral Source Regarding Disposition: | | | |
| Healthy Families Upper Peninsula (referral) | | Fax to: (906)293-5724 Call: (906)293-5107 x336 | |

Screen Completed by: _____ Agency: _____ Phone: _____