DEPARTMENT OF HEALTH
HUGS REFERRAL

TYPE OF REFERRAL: **Prenatal**
Postpartum
Parent/Guardian
Infant
Child

Referral Source: ______________ **Phone #:** _________________ **Date Referred:** ________________

Client Name: _____________________ **DOB:** ___________ **Age:** ______ **Sex:** ___ **Race:** _______

Child's SS#: _______________________ **Insurance/MCO:** _________________________________

Parent/ Guardian Name: _______________________________**SS#:** __________________________

Address: ____ **County:** _______________________

City: _____________________ **State:** ____ **Zip:** ____________ **Phone #:** _______________________

Primary Language: _______________________ **Primary Care Provider:** _______________________

Gravida ______ **Para** ______ **AB** ______ **EDC** _____________

Reasons for Referral (Check all that apply)

___ A) Homeless/ Transient
___ B) Domestic violence
___ C) History of or current DCS involvement
___ D) Physically challenged client or family member
___ E) History of chronic disease
___ F) History of pregnancy related complications
___ G) History of poor pregnancy outcomes
___ H) Lack of routine medical care (mother)
___ I) Late entry into prenatal care
___ J) Non-compliance with prenatal, postpartum or medical care
___ K) Failure to Thrive
___ L) Prematurity
___ M) Low Birth Weight
___ N) NICU Stay
___ O) Infant/ Child has special health needs
___ P) History of or current caregiver substance use
___ Q) More than one pregnancy in 1 year
___ R) More than 2 children under 3 years of age
___ S) Mentally challenged client or family member
___ T) Care giver with diagnosed mental illness (history of or current)
___ U) At risk for/ has identified developmental delays
___ V) No income or inadequate income
___ W) Education less than 12 years
___ X) Maternal age under 17 years
___ Y) First time mother
___ Z) Desires HUGS Services

OTHER REFERRALS FOR COMMUNITY-BASED SERVICES

____ DCS **____ Counseling Center**
____ MCO **____ Any Other**

Additional Information/ Concerns:

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____

FOR HUGS STAFF USE ONLY:

Date Referral Received: ________________

Core Family Members:

Name	DOB	Pop	Comments