



Referral Form for Parents as Teachers® Program

EBHV (Home Visiting) service for families prenatal to child's kindergarten entry

Hamilton County Health Department
921 East Third Street, Chattanooga, TN 37403

Telephone: 423-209-8298 / FAX: 423-209-8178
Email: jaimed@hamiltontn.gov

Date Referred:

Parent/Guardian Name:

DOB:

SS#:

Address:

Phone:

Cell:

Emergency Contact:

Language:

Children/Prenatal	Date of Birth/Due Date	Child's SS #

Family Characteristics: Check all appropriate for this family (must have at least one of these characteristics).

#	✓	Characteristic	#	✓	Characteristic
1.		Low Income Family	5.		Child has developmental delays or disabilities
2.		Pregnant woman or new mother/under age 21	6.		Has attained low student achievement or has a child(ren) with low student achievement
3.		Are users of tobacco products in the home	7.		Parent/caregiver history of or suspected current substance abuse or need substance abuse treatment
4.		History of current or suspected child abuse/neglect, or have had interaction with child welfare services	8.		Family members serving or has formerly served in the Armed Forces

Additional Information/Concerns: _____

Referral Request Source

Agency/Organization or Self:

Representative:

Representative's e-mail:

Telephone:

Agency Fax #:

FOR PAT USE ONLY

Date referral received by PAT:	NOTES
Date assigned to Parent Educator:	
Parent Educator assigned:	
<input type="checkbox"/> Enrolled	
<input type="checkbox"/> Wait List	
<input type="checkbox"/> Closed – Reason:	