Referral Form for Parents as Teachers® Program

Evidence Based Home Visiting service for families prenatal to child's kindergarten entry

Date Referred:
Parent/Guardian Name: **DOB:** **SS#:**
Address:
Phone: **Cell:** **Emergency Contact:**
Language:

Children/Prenatal	Date of Birth/Due Date	Child's SS # *(optional)*

Qualifying Factor:

	Prenatal or has a child under age 3

Family Characteristics: Check all appropriate (must have at least one):

√	Characteristic	√	Characteristic
	Low Income Family		Child has developmental delays or disabilities
	Pregnant woman/new mother under age 21		Low student achievement *(less than HS diploma)* or has a child(ren) with low student achievement
	Tobacco product use in the home		Caregiver history of substance abuse or need substance abuse treatment
	History of child abuse/neglect or have had interaction with child welfare services		Family members serving or has formerly served in the Armed Forces

Additional information or concerns: _____

_____

_____

Referral Source

Person Referring: **Title:**
Agency: **Phone:**
Email: **Fax #:**

Email/Fax To:

Hamilton County Health Department
921 East Third Street, Chattanooga, TN 37403
Phone: 423-209-8298

Email: HDPAT@hamiltontn.gov
Fax: 423-209-8178

FOR PAT USE ONLY

Date referral received by PAT:	NOTES
Date assigned to Parent Educator:	
Parent Educator assigned:	