Family Road Healthy Start
Referral Form

Name: _____ **Date** _____/_____/_____

Address _____
Street Apt#

_____ _____
City State Zip Parish

Race

□ African American □ Asian □ Caucasian □ Hispanic □ Other _____

D O B _____/_____/_____ Age _____

Phone # _____ Alt Phone #_____

How Did You Hear About Healthy Start?

□ Family/Friend □ TV/Radio/PSA □ Self - Referral □ Outreach Team _____

□ Human Service Provider _____ □ Health Provider_____

□ Other: (please specify) _____

Can Information be sent? □ Yes □ No Can follow-up calls be made? □ Yes □ No

Best time to call you: □ Anytime □ Morning □ Afternoon □ Evening

E-mail address: _____

Pregnancy History:

Are you pregnant? □ Yes □No

First pregnancy? □ Yes □No

(if no, check all that apply)

Live Births (Do you have any children?) □ Yes □ No
Miscarriage □ Yes □ No
Stillbirth □ Yes □ No
Termination □ Yes □ No

Age of your youngest child? _____

Current Pregnancy:

How many **weeks** pregnant are you? _____

Due Date: _____

Do you need information on any of these services or assistance in obtaining any of these services?

□ Prenatal Care
□ Parenting information
□ Employment
□ Childcare assistance
□ Transportation
□ Medical Condition requiring monitoring in pregnancy (Diabetes, Blood Pressure, etc.)
□ Adult Education/GED
□ Counseling needed for Substance Use (drugs, alcohol, tobacco)
□ Counseling (i.e. Relationship Issues, Personal Issues, etc.)
□ Information on How to Stay Healthy During Pregnancy
□ Other _____

FAMILY ROAD HEALTHY START
PRELIMINARY RISK SCREENING TOOL

Name: _____ Date Screening Tool Completed: _____

Person Completing Form: _____

1. Do you have children? [ ] Yes [ ] No How many? _____ Ages? _____

2. Have you had any:

	Yes	No	How many/when?
Miscarriages	[ ]	[ ]	_____
Abortions	[ ]	[ ]	_____
Stillbirths	[ ]	[ ]	_____
Low Birth Weight Births (>5lbs 6oz)	[ ]	[ ]	_____
Preterm Births (>37 weeks)	[ ]	[ ]	_____
Infant Death (28 days or less)	[ ]	[ ]	_____

3. Have you previously been treated for any of the conditions below or are you currently being treated for any of these conditions:

	Previously Received Treatment		Currently Receiving Treatment		
	Yes	No		Yes	No
Diabetes	[ ]	[ ]	Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Sexually transmitted diseases/infections	[ ]	[ ]	Sexually transmitted diseases/infections	[ ]	[ ]
Mental Health counseling	[ ]	[ ]	Mental Health counseling	[ ]	[ ]
High Risk Prenatal Care	[ ]	[ ]	High Risk Prenatal Care	[ ]	[ ]
HIV/AIDS	[ ]	[ ]	HIV/AIDS	[ ]	[ ]
Depression	[ ]	[ ]	Depression	[ ]	[ ]
Diagnosis of psychiatric condition	[ ]	[ ]	Diagnosis of psychiatric condition	[ ]	[ ]

4. If you could change the timing of this pregnancy, would you want the pregnancy to be …….?
[ ] earlier [ ] later [ ] not at all [ ] no change [ ] Not pregnant

5. Has your current partner ever hit or threatened you? [ ] Yes [ ] No

6. Are you homeless? [ ] Yes [ ] No

7. In the last month, have you:

	Yes	No
Smoked cigarettes	[ ]	[ ]
Drank alcohol	[ ]	[ ]
Used drugs	[ ]	[ ]

OFFICE USE ONLY

Risk Level assigned from scoring of the Preliminary Risk Screening Tool:

[ ] Level One [ ] Level Two [ ] Level Three Supervisor's Initials: _____

Case Manager referral assigned to: _____ Date Assigned: _____

Comments: _____