

Family CORE

Coordinated 0-5 years Referral Exchange

Referral form for prenatal, infant and young children home visitation programs

Those with chronic medical conditions are eligible up to age 21 years

Clients with or without insurance are eligible for programs

Please fax this form to **503-857-0767**.

The person or family being referred will be contacted.

We will provide a follow-up letter to you regarding the outcome of the referral.

For questions or mailed submissions please call 503-376-7426.

807 NE 3rd St., McMinnville, OR 97128

Date: _____

Child OR pregnant women being referred:

Date of Birth: _____

Due Date (if applicable) _____

Parent or Guardian names (if a child):

Relationship: _____ Date of Birth: _____

Relationship: _____ Date of Birth: _____

Phone number _____

Home address _____

Primary Language _____

Race/Ethnicity White Hispanic/Latino Black/African American Native American Other

Please check all that apply

- | | |
|--|---|
| <input type="radio"/> Medical condition
Please specify _____ | <input type="radio"/> Newly pregnant needing assistance |
| <input type="radio"/> Teen parent | <input type="radio"/> Limited income/resources (i.e. lack of transportation, food, housing) |
| <input type="radio"/> Parent with developmental delays | <input type="radio"/> Lack of adequate parenting skills |
| <input type="radio"/> Child with or at risk for developmental delays | <input type="radio"/> Domestic violence (present or history of) |
| <input type="radio"/> Infant feeding/weight gain problems | <input type="radio"/> Lack of client/patient follow through |
| <input type="radio"/> Risk of maternal depression | <input type="radio"/> Substance abuse- <i>please describe below</i> |
| <input type="radio"/> Isolation/lack of support | <input type="radio"/> Tobacco Use |
| <input type="radio"/> Challenging child behaviors | <input type="radio"/> DHS involvement |
| | <input type="radio"/> Other- <i>please describe below</i> |

Additional Information:

Referring Source Information:

Person (provider) to receive referral follow-up information: _____

Agency/Organization: _____

Phone Number: _____ Fax Number: _____

For Internal Family CORE use only

A Family Place Relief Nursery
Babies First
CaCoon
Early Head Start/Head Start

Early Intervention/Early Childhood Special Education
Healthy Families
Maternity Case Management
Mothers and Babies
Responsible Moms