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| **IDENTIFIED ADULT CLIENT FOR SERVICES** |
| **Name:**      |  **DOB:**       |
| **Home address:**       | **City:**       | **State:**       | **Zip code:**       |
| **Primary phone:**       | **[ ]** Call **[ ]** Text  | **Interpreter needed: [ ]** Yes **[ ]** No |
| **Email or Alternate Phone:**       | **Language:**       |
| **Children or others living in the household:** |
| **Name:**       | **DOB:**       | **Relationship to client:**       |
| **Name:**       | **DOB:**       | **Relationship to client:**       |
| **Name:**       | **DOB:**       | **Relationship to client:**       |
| **Name:**       | **DOB:**       | **Relationship to client:**       |
| **Name:**       | **DOB:**       | **Relationship to client:**       |
| **If person being referred is pregnant, please complete the following fields:** |
| **Is this a first pregnancy?** [ ]  Yes [ ]  No **Due Date:**        | **Insurance:** [ ]  Medicaid [ ]  Private [ ]  None |
| **Priority Consideration:**  | **Reasons for Referral:**  |
| **[ ]  Smoker/vaping** **[ ]  1 or more children under 3 years** **[ ]** **Education below 10th grade** **[ ]  Mental health concerns**  **Diagnosis:**      **[ ]  Lack of prenatal care** **[ ]  Substance use** **[ ] Self [ ] Partner** **[ ]  Traumatic history (neglect, abuse)** **[ ]  DCYF involvement last 12 months****[ ]  Domestic violence** [ ] Current [ ] Past | **[ ]  Developmental screening** **[ ]  Unsafe or unhealthy**  **conditions in the home** **[ ]  Stress management** **[ ]  Nutrition** **[ ]  Safety concerns** **[ ]  Support group/play group** **[ ]  Budgeting/organizational**  **skills**  | **[ ]  Parenting**  **(discipline, child development)****[ ]  Pregnancy & breastfeeding education****[ ]  Assistance with community resources****[ ]  Child care needs/concerns** **[ ]  Other:**      |
| **Further explanation or description:**       |
| **Referring Agency:**       | **Date:**       |
| **Contact Person:**        | **Phone:**       |
| **I give consent for this referral and for communication between Waypoint and the referring agency regarding this referral.** **Signature of client:**      |