

Family CORE

Coordinated 0-5 years Referral Exchange

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

Please fax this form to **503-472-9731**.

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 Public Health 503-434-7525

412 NE Ford Street, McMinnville, OR 97128

Date: _____

Person being referred:

Date of Birth: _____

Parent or Guardian names (if a child):

Relationship: _____

Date of Birth: _____

Relationship: _____

Date of Birth: _____

Phone number _____

Home address _____

Primary Language _____

Does the family know about this referral YES NO

Please check all that apply

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

Additional Information:

Referring Source Information:

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

Person/Organization completing referral form: _____

Phone Number: _____ Fax Number: _____

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

Early Intervention/Early Childhood Special Education
Healthy Families ~ Healthy Start
Maternity Case Management
Mothers and Babies