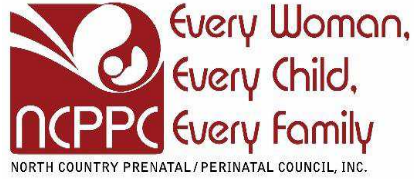

Community Health Worker Program/Healthy Families New York Program Referral Form

Must have at LEAST one of the following factors (Check all that apply)

- ☐ High need individual(s) need of insurance or a healthcare provider
- ☐ Woman that had a previous fetal/infant loss, preterm, or low birth weight baby
- ☐ High risk pregnancy (preeclampsia, gestational diabetes, obesity, etc.)
- ☐ Psychosocial problems (domestic violence, mental health disorder, poor nutrition)
- ☐ Substance/alcohol/tobacco use
- ☐ Teenage pregnancy (under the age of 21)
- ☐ Parenting Challenges (single, inadequate income, complex social concerns)
- ☐ Any person needing help managing an illness and/or making lifestyle changes for self and family

Client Name: **Date of Birth:**

Phone Number: **Alternate Phone Number:**

Address:

Client Signature:

*By signing I agree to allow our programs to coordinate services with the referring agency

Name of Person Making the Referral: **Phone/Fax #:**

Agency:

Date of Referral:

Reason for Referral:

Outcome of Referral:

Assigned Case Manager: **Date Returned to Source:**

Please fax or mail referral to:

North Country Prenatal/Perinatal Council
ATTN: CHW Supervisor
200 Washington Street, Suite 300
Watertown, NY 13601
Fax-315.788.1726/Phone-315.788.8533