FamilyCore Referral Form

Coordinated 0-5 years Referral Exchange

Referral form for prenatal, infant, and children 0-5 for 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 OR email to earlylearning@yamhillcco.org

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 email us.

807 NE 3rd St. McMinnville, OR 97128

Date: _____

This referral applies to: ☐ A child ☐ A family ☐ a parent/caregiver ☐ An expectant (pregnant) person

Name of parent/caregiver: _____**Relationship:** _____**Date of birth:** _____

_____**Relationship:** _____ **Date of birth:** _____

Child's name: _____ **Date of birth:** _____**Child's age:** _____

Additional child being referred: _____**Date of birth:** _____**Child's age:** ____

Due date/date of arrival (if pregnant or expecting): _____

Phone number of parent/caregiver or family: _____

Email address: _____

Home address: _____

Mailing address (if different): _____

Preferred method of contact: ☐ Email ☐ Phone call ☐ Text message

Primary language: ☐ English ☐ Spanish _____Other, please specify

Race/ethnicity:

- ☐ Caucasian
- ☐ Hispanic/Latino
- ☐ Black/African American
- ☐ Native American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Prefers not to answer
- ☐ Other (please specify): _____

Family is experiencing (check all that apply):

- ☐ Pregnancy/expecting a new child
- ☐ First birth
- ☐ Medical condition: _____
- ☐ Feeding/weight gain problems
- ☐ Developmental delay/diagnosed disability
- ☐ Concerns about my child's milestones
- ☐ Parent with developmental delays
- ☐ A parent under age 21

- ☐ Maternal or paternal depression (baby blues)
- ☐ Isolation/lack of support
- ☐ Migrant/seasonal work
- ☐ Substance abuse/recovery (past or present)
- ☐ A parent who is incarcerated or recently incarcerated
- ☐ Concerns about violence or safety
- ☐ Housing instability/homelessness
- ☐ Other (please specify): _____

Additional information (please list as much information as possible about the referral):

Family would like to learn more about (check all that apply):

- ☐ Infant/child nutrition
- ☐ Parenting skills
- ☐ Child development and milestones
- ☐ Maternal or paternal depression (baby blues)
- ☐ Birth supports/doula services
- ☐ Keeping my family safe
- ☐ Substance abuse/recovery support
- ☐ Connecting to other parents
- ☐ Case management/care coordination
- ☐ Quitting tobacco
- ☐ Other (please specify): _____

Referring Source Information:

Person or provider to receive referral follow-up information: _____

Agency or organization: _____

Phone number: _____

Email: _____

Fax number: _____

Sector (referred by):

- ☐ Hospital
- ☐ Clinic
- ☐ School
- ☐ Social Services Agency
- ☐ Faith Community
- ☐ Other (please specify): _____

By submitting this form, I attest that the family is aware of the referral:

- ☐ I attest

This form was last modified on 10/05/2022