



# Referral to NFP Program



Please complete this form with the client and fax to BCHHS- Nurse Family Partnership 828-250-6095.

Please call 828-250-5063 with any questions/problems.

## Client Consent

I voluntarily consent to having a referral sent to the NFP program on my behalf. \_\_\_\_\_  
Signature of Client / Parent / Legally Responsible Person

I voluntarily consent for the NFP program to share my enrollment status with the referring agency. \_\_\_\_\_  
Signature of Client / Parent / Legally Responsible Person

*(The referring agency will be notified of the client referral outcome within 30 days when consent is provided by the client.)*

## Client Contact Information

Date of Referral:	First Name:	Last Name:
DOB:	EDD:	Prenatal Provider:
Race:	Ethnicity:	Primary Language:
Street Address:		City/State/Zip Code:
Phone Number:	Best time to call:	Can a message be left?
Alternative Contact Person(s) and/or Numbers(s):		

## Referral Criteria

- Client is a primip - Client's first pregnancy or client has had no previous live births. Client is low income (qualifies for Medicaid, Food Stamps and/or WIC) and client is currently less than 29 weeks gestation.
- Client is a multip – Client has had one or more previous live births. Client is low income (*qualifies for Medicaid, Food Stamps and/or WIC*); client is currently less than 29 weeks gestation; client has not participated in more than 8 home visits with a NFP program in the past.

## Referral Source

Primary Referral Source Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Referral Agency Program Name: \_\_\_\_\_

For NFP Agency Use Only:	Client Risk Factors
<input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Previous low birth weight baby <input type="checkbox"/> Currently homeless <input type="checkbox"/> Mental health diagnosis or concerns <input type="checkbox"/> Recent history or current substance use <input type="checkbox"/> Previous or current involvement with child welfare	<input type="checkbox"/> History or current intimate partner violence <input type="checkbox"/> Less than high school education or GED <input type="checkbox"/> 19 years or younger <input type="checkbox"/> Developmental disabilities <input type="checkbox"/> Medical conditions requiring MD management <input type="checkbox"/> Other concerns _____
Client met NFP referral criteria for Primip Program <input type="checkbox"/> Yes <input type="checkbox"/> No	
Client met NFP referral criteria for Multip Program <input type="checkbox"/> Yes <input type="checkbox"/> No	