Family CORE

Coordinated 0-5 years Referral Exchange

Referral form for prenatal, infant and young children 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.

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 503-376-7423.
807 NE 3rd St., McMinnville, OR 97128

Date: _____

Child OR pregnant women being referred:

_____ **Date of Birth**: _____

Estimated due date _____ **First Birth:** ☐

Parent or Guardian names (if a child):

_____Relationship:_____ Date of Birth: _____
_____Relationship:_____ Date of Birth: _____

Phone number _____
Home address _____

Primary Language_____
Race/Ethnicity White ○ **Hispanic/Latino** ○ **Black/African American** ○ **Native American** ○ **Other** ⊙

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
- ☐ Case management/care coordination
- ☐ Parent incarcerated or recently incarcerated
- ☐ Parenting class/parent group
- ☐ Domestic violence (present or history of)
- ☐ Child safety concerns
- ☐ Substance abuse-*please describe below*
- ☐ Tobacco Use
- ☐ DHS involvement- please describe below
- ☐ Other- *please describe below*

Additional Information:

_____
_____
_____

Referring Source Information:

Person (provider) to receive referral follow-up information: _____
Agency/Organization:_____
Phone Number: _____ Fax Number: _____

For Internal Family CORE use only

A Family Place Relief Nursery
Babies First
CaCoon
Early Head Start/Head Start
NFP
Healthy Families
Maternity Case Management
Mothers and Babies
Responsible Moms
Responsible Dads