Healthy Families-Healthy Babies

Public Health Prenatal Referral Form

Name _____

Address _____

_____

Telephone (home) _____ (other) _____

Date of birth _____ Age _____

Medicare number

OR

If addressograph/sticker is inserted please ensure that client's address is included.

Expected date of delivery _____ / _____ / _____ (year / month / day)

G _____ P _____ A _____

School _____

Preferred language of service E _____ F _____

Family physician/Nurse practitioner _____

Specialist _____

Other agencies or services involved/referrals to other services _____

☐ Prenatal book *Healthy Pregnancy - Healthy Baby: A New Life*, given to client

Reason for referral. Check all that apply. Please refer your client regardless of what is checked below. This information assists a Public Health nurse / dietitian in determining eligibility for nutrition supplements and/or home visitation. Upon receipt of this referral, Public Health staff will contact your client to assess eligibility for services. Any non-eligible clients may be referred to other community prenatal services.

Please check ☑ the reasons for referral | **Comments (if applicable):**

- ☐ First time mother _____
- ☐ Age ≤ 19 years _____
- ☐ Education level _____
- ☐ Smoking _____
- ☐ Insufficient finances _____
- ☐ Social assistance recipient _____
- ☐ Alcohol/Drug use _____
- ☐ Other reasons (please specify) _____

Client informed of this referral ☐ Yes ☐ No

Return form to your local Public Health Office

Name _____ Date _____

Signature _____ Telephone _____

Agency: ☐ Hospital/clinic ☐ Physician/Nurse practitioner ☐ Other (please specify) _____

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RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

New Nouveau Brunswick

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