Referrals to NFP Program

Referral Information:

First Name _____ Last Name _____

Date of Birth _____ Due Date _____

Preferred Language _____ Race _____

Ethnicity ☐ Hispanic or Latina ☐ not Hispanic or Latina

Eligible for WIC or Medicaid? ☐ Yes ☐ No Permission to give information to NFP? ☐ Yes ☐ No

911 Address _____

_____

City _____ State _____

Zip Code _____ Email _____

Cell Phone _____ Home phone _____

Work Phone _____ ☐ Declined to provide cell phone #

Emergency Contact _____ Phone _____

Referral Source:

Date of Referral _____ Primary Source Name _____

Location _____ Phone # _____

Follow-up Nurse Home Visitor _____

Contact Log _____

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Referral Source Code: (Mark primary source)

- ☐ Adult healthcare provider or clinic (NOT OB care provider)
- ☐ Bill board
- ☐ Broadcast (TV, radio)
- ☐ Child welfare services
- ☐ Community event
- ☐ Developmental disability services
- ☐ Food stamps
- ☐ Health plan
- ☐ Hospital (ER, inpatient, or other hospital services- not clinics or provider)
- ☐ Judicial system
- ☐ Medicaid
- ☐ Mental health treatment services
- ☐ News media article or show
- ☐ NFP client (current or past)
- ☐ NSO
- ☐ Obstetrical healthcare provider or clinic
- ☐ Online
- ☐ Other (none of the above)
- ☐ Other home visiting program
- ☐ Outreach worker
- ☐ Pediatric healthcare provider or clinic
- ☐ Pregnancy testing clinic (NOT OB provider)
- ☐ Public sign
- ☐ School
- ☐ Substance use treatment provider or clinic
- ☐ TANF
- ☐ Unknown
- ☐ WIC

Referral Disposition Code (Dismissal Reason):

☐ Already enrolled in another program ☐ Did not meet local criteria ☐ Did not meet NFP criteria

☐ Enrolled in NFP, consent signed ☐ Insufficient referral information ☐ Miscarried/fetal death

☐ Program full ☐ Refused participation ☐ Unable to locate ☐ Unable to serve client due to language

Nurse Family-Partnership

Eastern Band of Cherokee Indians

P.O. Box 666

Cherokee, NC 28719

828-359-6250

Last Name_____ First Name_____ MI_____

D.O.B._____ Race_____

Physical Address_____

_____

Phone #_____

Emergency Contact_____ Phone #_____

EDD_____ Medical Provider_____

G___T___P___A___L___ Initial B/P_____ Pregravid wt. _____ Ht._____

RISK FACTORS (ex. HTN, diabetes, psychiatric illness)_____

_____

_____

*Referral Source Signature*_____ *Physician Signature*_____