Tulsa Health Department healthy start

REFERRAL TO HEALTHY START-THD SERVICES

Fax completed form to Healthy Start-THD: (918) 595-4282

Referring Agency Information

Referral Date: _____ **Prenatal Provider / Physician:** _____

Referring Agency: _____ **Contact Name / Title:** _____

Phone: _____ **Email:** _____

Mother's Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address (street, apt. #, city, state): _____ **Zip Code:** _____

Age: _____ **Date of Birth:** _____ **Phone #:** _____/ **Alt. Phone #:** _____

Spoken Language: _____ **Best Time to Contact:** ____ Morning ____ Noon hour ____ Afternoon _____ Other

Weeks Pregnant (when appropriate)**:** _____ **Estimated Due Date:** _____ **First-time Pregnancy:** ____ Yes ____ No

Parent/Guardian (if client is a minor): _____ **Phone #:** _____

Reason for Referral *(mark all that apply)*

_____ Non-pregnant/ICC _____ Pregnant _____ Postpartum _____ Parenting / Child (child under 18 months) *Age of child*: _____

_____ Previous infant death _____ Received late / no prenatal care during current or previous pregnancy

_____ Previous pre-term or LBW birth _____ Previous complicated pregnancy or maternal health complication

_____ First time Mom/Dad _____ Family Violence _____ Lack of Basic Needs
_____ Pregnant/Parenting Teen _____ Tobacco Use _____ Substance/Alcohol Use
_____ Mental Health _____ Housing _____ Other: _____

Healthy Start Use ONLY

Intake Date: _____ Staff completing Intake: _____ Enrollment Date: _____

Case Manager assigned: _____ Referring Agency notified of outcome: _____ Yes _____ N/A

Summary of Attempts for Initial Contact

Date:					
_____	Contact Outcome:	_____ Unable to contact	_____ Relocated	_____ Declined	_____ Accepted
_____	Contact Outcome:	_____ Unable to contact	_____ Relocated	_____ Declined	_____ Accepted
_____	Contact Outcome:	_____ Unable to contact	_____ Relocated	_____ Declined	_____ Accepted

Notes: