Attachment A

COUNTY OF LOS ANGELES
Public Health

Nurse-Family Partnership
Helping First-Time Parents Succeed

NURSE-FAMILY PARTNERSHIP PROGRAM
Confidential Referral Form
Fax this form to (213) 639-1035

****REFERRALS ACCEPTED FOR CLIENTS WHO ARE LESS THAN 24 WEEKS PREGNANT****

☐ First pregnancy (no previous live birth and at least one primary risk factor below) **OR**

☐ Pregnant and parenting: Client MUST have a minimum of one secondary risk factor below.

Date: _____ **Person making referral**: _____

Email address: _____ Phone # _____

Agency name: _____ Fax #: _____

Client / Youth name: ____ Birth date: _____

Email address (if known):_____ LMP date:_____

Address: _____ Delivery date:_____

Phone: home_____/Cell: _____ Ethnicity:_____

Does client understand English? ☐ Yes ☐ NO Preferred language: _____

Was client informed about this referral? ☐ Yes ☐ NO MediCal beneficiary? ☐ Yes ☐ NO

Is pregnancy confidential to the family? ☐ Yes ☐ NO MediCal eligible? ☐ Yes ☐ NO

Primary risk factors: (Known/Suspected--Please check all that apply)

☐ Deaf / hard of hearing ☐ Suspected drug use ☐ Foster child

☐ Blind / sight impaired ☐ Mental health condition:_____

☐ Physical disabilities ☐ Exposed to violence ☐ Transitional youth (16 –24 y.o.)

☐ Juvenile / adult justice ☐ No support system ☐ Unstable housing

☐ Trauma exposure ☐ Stressed family ☐ Unsafe living conditions

☐ Other: _____

Secondary Risk Factors: For Pregnant AND Parenting client, must select one of the following criteria:

☐ Previous Pre-term birth (<37 wks) ☐ Previous low birthweight baby (< 5 lb 8 oz.) ☐ Homeless

☐ Mental health concerns ☐ Previous or current involvement with child welfare

☐ Hx of intimate partner violence ☐ 19 years or younger ☐ Developmental disabilities

☐ Less than HS education or GED ☐ Medically complex, describe: _____

☐ Other: _____

Comment: