



**Intake/Referral**

Child's Last Name \_\_\_\_\_ M.I. \_\_\_\_\_ First Name \_\_\_\_\_

Birth/Due Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: Male  Female  Child one of set of: twins \_\_ triplets \_\_

<b>Ethnicity:</b> <input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Mexican/Mexican American/Chicana	<input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Other Hispanic/Latino <input type="checkbox"/> Unknown
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<b>RACE(S):</b>		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Samoan	<input type="checkbox"/> Korean
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other
<input type="checkbox"/> Filipino	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Japanese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Unknown
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian or Chomorro	<input type="checkbox"/> White
<input type="checkbox"/> Other Asian		

Child's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Native Language: \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

~~~~~ Primary Caregiver ~~~~~

Last Name \_\_\_\_\_ M.I. \_\_\_\_\_ First Name \_\_\_\_\_

Primary Phone# ( ) \_\_\_\_\_ Secondary Phone# ( ) \_\_\_\_\_

~~~~~ Relationship to Child ~~~~~

|                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Mother      | <input type="checkbox"/> Step Parent   | Caregiver's D.O.B. ____ - ____ - ____<br>Social Security # ____ - ____ - ____ |
| <input type="checkbox"/> Father      | <input type="checkbox"/> Foster Parent |   |
| <input type="checkbox"/> Grandparent | <input type="checkbox"/> Caregiver     |   |

|                                 |
|---------------------------------|
| Name Of Person Referring: _____ |
| Agency/Organization: _____      |
| Phone # : _____ Fax # : _____   |

Referring To: Newborn Home Visit  Help Me Grow (At Risk or Part C)   
Request for Parent Support: Yes  No

~~~~~ Reason(s) for Referral ~~~~~

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Verbal Permission from Caregiver / Legal Custodian: Yes  No   
To make referral, fax to: **Help Me Grow** at 330.376.1226 \*\*\*\*\* Date Referral Sent \_\_\_\_ - \_\_\_\_ - \_\_\_\_