



home visiting

REFERRAL FORM

Complete this form and fax to 302-295-5988 or email Helpmegrow@uwde.org.
Potential clients can self-refer by calling 2-1-1 or texting 302-231-1464.

If referral is under 18

PARENT OR LEGAL GUARDIAN CONTACT NAME

Is it Ok to contact this person in reference to this referral?

Yes

No

RELATIONSHIP

PHONE

(DATE OF REFERRAL)

(CLIENT NAME)

(DATE OF BIRTH)

(ESTIMATED DUE DATE)

(EMAIL ADDRESS)

(ADDRESS)

(ADDRESS 2)

(CITY)

(ZIP)

(HOME PHONE)

(CELLPHONE)

Preferred method of communication Client prefers text Client prefers phone call Client prefers email

(CHILD NAME)

(CHILD DATE OF BIRTH)

Primary Language English Spanish Creole Other: _____
(OTHER LANGUAGE)

Race African American Asian Biracial Caucasian Hawaiian/Pacific Islander

Hispanic Native American Other: _____
(OTHER ETHNICITY/RACE)

Marital Status Single Married Separated Divorced Widowed

Does client receive any of the following? Medicaid TANF Food Stamps WIC

(OBGYN)

(PEDIATRICIAN)

Some Potential Risk Factors for Consideration to Make a Referral (please check those that apply):

Is the client being referred involved with DFS? Yes No

If yes, is there a Plan of Safe Care (POSC) in place? Yes No

- | | | |
|---|---|--|
| <input type="checkbox"/> Teen parent | <input type="checkbox"/> Low income | <input type="checkbox"/> Child abuse or neglect |
| <input type="checkbox"/> Child w/ disability or chronic health condition | <input type="checkbox"/> Recent immigrant or refugee family | <input type="checkbox"/> Death in the immediate family |
| <input type="checkbox"/> Parent w/ disability or chronic health condition | <input type="checkbox"/> Substance use disorder | <input type="checkbox"/> Foster care or other temporary caregiver |
| <input type="checkbox"/> Parent w/ mental health issue(s) | <input type="checkbox"/> Housing instability | <input type="checkbox"/> Military deployment |
| <input type="checkbox"/> Low educational attainment | <input type="checkbox"/> Very low birth weight | <input type="checkbox"/> Parent incarcerated during the child's lifetime |
| | <input type="checkbox"/> Intimate partner violence | |

(NAME OF PERSON)

(PHONE NUMBER)

(EMAIL ADDRESS)

(AGENCY)

