* REQUIRED *

Improving Pregnancy Outcomes - Every Women Counts
The Children's Home Society of New Jersey
Initial Referral Form

PLEASE PRINT CLEARLY

*Date of Referral ___ - ___ - ___

Participant Information

*Last Name ______ *First Name ______ *Date of Birth ___ - ___ - ___

*Street Address ______ *City ______

*Zip Code ______ *County ______ Participant ID ______

***Primary Language** (Choose one)
- O English
- O Spanish
- O Other ______

***Race** (Choose one)
- O Black
- O White
- O Asian
- O Native American
- O Multi-Racial
- O Alaskan/Pacific Islander
- O Other ______

***Ethnicity** Hispanic O Yes O No

***Health Insurance** (Select all that apply)
- O Medicaid PE
- O Medicaid MC
- O NJ Family Care
- O Medicare
- O Commercial/Private
- O Uninsured/Self Pay

Participant Contact Information

*Primary Phone ___ - ___ - ___

Alternate Phone ___ - ___ - ___

Email Address ______

***Preferred Contact Method** (Choose one)
- O Primary Phone
- O Email
- O Alternate Phone
- O Text

***At which phone number can we text you?**
- O Primary
- O None
- O Alternate

* Household Information

Married? O Yes O No

\# of Children in the home ☐☐

Date(s) of birth of children needing services	Name of Child	Relationship
1. ___ / ___ / ___	______	______
2. ___ / ___ / ___	______	______
3. ___ / ___ / ___	______	______

Participant Is... (Choose One)

O Preconceptional Woman	O Pregnant Woman	O Interconceptional Woman	O Male
Has no children and has never been pregnant.	* First Time Parent? O Yes O No * In Prenatal Care? O Yes O No * Due Date ___ - ___ - ___	*Previously pregnant and not currently pregnant. (Does not matter if woman has children.)* * First Time Parent? O Yes O No	* Are you a Parent? O Yes O No * First Time Parent? O Yes O No Does your child live w/ you? O Yes O No

Reason for Referral - Household Needs

- __ Primary care for myself
- __ Primary care for my children
- __ Prenatal care
- __ Public benefits
- __ In-home parent support (home visiting)
- __ Assistance connecting to services (CHW)
- __ Group parent support
- __ Other______

Referral Agency Information

*Referral Agency Name ______

Name of Person Making the Referral ______ Phone ___ - ___ - ___

Email Address ______ Phone Extension ______

Comments

* **Participant Consent**

I agree to provide the information above and to have it forwarded as a referral to available service agencies in my community. I agree to be contacted, and for Community Based Services staff to follow-up with me or the agency to which I was referred to support my care.

O **Oral consent given**

Signature of Participant

Sign ______ *Print* ______

Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

Program Use Only

Date Pregnancy Test Given ___ - ___ - ___

Pregnancy Test Positive? O Yes O No

Outreach Type
- O Agency
- O Door to Door
- O Self
- O Event *(Specify)*______

Fax# **(732) 557-5078**

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