Partnership for Maternal and Child Health of Northern New Jersey
Hudson County Central Intake
Initial Referral Form

* REQUIRED *

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)*
- ○ English
- ○ Spanish
- ○ Other _____

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

***Ethnicity** Hispanic ○ Yes ○ No

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

Participant Contact Information

*Primary Phone ___ - ___ - ___

Alternate Phone ___ - ___ - ___

Email Address _____

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

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

*Household Information

Married? ○ Yes ○ 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)*

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

Program Use Only

Date Pregnancy Test Given ___ - ___ - ___

Pregnancy Test Positive? ○ Yes ○ No

Outreach Type
- ○ Agency
- ○ Door to Door
- ○ Self
- ○ Event *(Specify)* _____

* 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.

○ 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.

Please FAX form to 201-204-4056 or E-MAIL to dpicon@partnershipmch.org

Rev 062015