



Rhode Island
Maternal and Child Family Home Visiting System
Referral Form

If you feel a pregnant woman or family would benefit from support or services in their home, please fax this form to the First Connections agency in their community, an Early Intervention program, or to RIDOH at 401-222-1442. See the back of this form for a list of agencies.

Name of Referrer	Date / /
Agency / Provider	Position Title
Phone	Fax
Email	

1. Parent / Guardian Information

First Name	Last Name
Birth Date	Relationship to Child
First Time Mother <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date / /
Language - Primary	Preferred
Street Address	City, RI ZIP Code
Mailing Address (if different)	City, RI ZIP Code
Home Phone	Cell Phone
Email	
Preferred Contact Method	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Text <input type="checkbox"/> Other
Highest Education	<input type="checkbox"/> < high school (HS) <input type="checkbox"/> Some HS <input type="checkbox"/> HSDiploma/GED <input type="checkbox"/> Some/all college/advanced degree
Insurance Type	<input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> None

2. Child Information

First Name	Last Name
Birth Date / /	
Street Address	City, RI ZIP Code

3. Parent / Guardian of Minor Pregnant Woman Information

First Name	Last Name
Language - Primary	Primary Phone
Street Address	City, RI ZIP Code

Relationship to Pregnant Woman

4. Reason for Referral

<input type="checkbox"/> Basic Needs	<input type="checkbox"/> Breastfeeding Support	<input type="checkbox"/> Cash Assistance / Medical Assistance
<input type="checkbox"/> Child development questions	<input type="checkbox"/> Community Resources	<input type="checkbox"/> Comprehensive Evaluation (EI only)
<input type="checkbox"/> Developmental Screening	<input type="checkbox"/> Social and Emotional Support	<input type="checkbox"/> New Parent
<input type="checkbox"/> Parent Education / Support	<input type="checkbox"/> Other	

Developmental Screening Results Sent with Referral? Yes No **Additional Attachments Included?** Yes No

5. Consent to Refer and Release of Information

I, _____, give my permission for _____ to share the
 (Name of parent/guardian) (Name of program referred to)
 results of this referral with _____. Information shared will include verification
 (Name of referral source)

that my referral is in process, whether my child is eligible, and my enrollment status. This information is needed to help coordinate services for which I may be eligible.

Signature*: _____ Date: ___ / ___ / _____

*I hereby agree that information may be shared with the family visiting programs listed on the back of this form and that I may be contacted by one of those agencies. One of the family visiting agencies will provide the referral source with the outcome of the referral.