Huron Perth Public Health

HEALTHY BABIES HEALTHY CHILDREN PROGRAM
REFERRAL FORM

Referral Type	
☐ Prenatal ☐ Postpartum (birth to 6 weeks) ☐ Early Identification (7 weeks to 6 years)	Date of Referral: (yyyy-mm-dd)
Client referred by:	Relationship/Agency:
Referral taken by:	

Client Information		
Last Name:	First Name:	Date of Birth: (yyyy-mm-dd)
Address:		Phone:

Preferred method of contact: ☐ Telephone/Cell ☐ Text only ☐ Email:

Alternate contact number: (optional)

Additional Family Members			
First & Last Name	Date of Birth (yyyy-mm-dd)	First & Last Name	Date of Birth (yyyy-mm-dd)

Reason for Referral/Family Stressors (new to area, finances, housing, support, domestic violence, cultural/language, transportation, parenting concerns)

Services the Family is Involved With:

Family Physician:	Phone:

☐ Ontario Works ☐ Children's Aid Society ☐ Ontario Disability Support Program ☐ Huron Perth Centre
☐ Child & Parent Resource Institute ☐ smallTALK

☐ Other (medical specialist, social worker/counsellor, dietitian):

I give my consent and authorization for the above information to be sent to the Health Unit in my county for the purposes of the Healthy Babies, Healthy Children program. I understand that I will be contacted by a Public Health Nurse.

Verbal consent provided by client. ☐ **Yes** ☐ **No**	Date (yyyy-mm-dd)

Personal or personal health information on this form is collected under the authority of the *Health Protection and Promotion Act* and applicable privacy legislation. This information will be used for delivery of public health programs and services and may be used for evaluation or statistical purposes. Any questions about the collection of this information should be directed to the HBHC Manager, Huron Perth Public Health, 1-888-221-2133.

Fax form to: 519-271-8243 or toll-free 1-855-271-8243