

Healthy Families of Burnett County Home Visiting Program

Screening and Referral Form



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR OFFICE USE ONLY Date Received:\_\_\_\_\_\_\_\_\_\_\_\_ 1st Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAISEY #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE:\_\_\_\_\_\_\_\_\_\_\_\_

GENDER: \_\_\_Male \_\_\_Female \_\_\_Other \_\_\_Choose not to disclose

PARTNER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_

GENDER: \_\_\_Male \_\_\_Female \_\_\_Other \_\_\_Choose not to disclose

ETHNICITY: \_\_\_Non-Hispanic \_\_\_Hispanic \_\_\_Other

PARENT RACE: \_\_\_Native American \_\_\_Asian \_\_\_Black \_\_\_Hawaiian \_\_\_White \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd PARENT RACE: \_\_\_Native American \_\_\_Asian \_\_\_Black \_\_\_Hawaiian \_\_\_White \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BABY RACE: \_\_\_Native American \_\_\_Asian \_\_\_Black \_\_\_Hawaiian \_\_\_White \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? \_\_\_yes \_\_\_no \_\_\_unknown If YES, due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If NO, INFANT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

PRIMARY ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTY: \_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALTERNATE PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALTERNATE CONTACT NAME & NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGENCY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my permission to release this information to the Healthy Families of Burnett County Home Visiting Program. I understand this referral will not be released to other programs. I give permission to be contacted by a Healthy Families of Burnett County Home Visiting Program staff person.

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fax referral form to: Burnett County Family Resource Center, Inc. 715-349-5331

Healthy Families of Burnett County Home Visiting Program

Screening and Referral Form

|  |  |
| --- | --- |
| Date: | Client Name: |
| **Risk Factor** | **Definition** |
| Low income family?  \_\_yes \_\_no  \_\_unknown | A family whose total annual income before taxes is equal to, or less than, 200% of the Federal  Poverty Threshold. AND/OR: if the family is receiving SSI, or if families qualify for Head Start,  WIC Child Care subsidy, free/reduced lunch, TANF, Food Share, or BadgerCare. |
| Pregnant woman under  21 years?  \_\_yes \_\_no  \_\_unknown | A current pregnancy occurring in a woman under 21 years. |
| History of child  maltreatment or  interactions with Child  Welfare?  \_\_yes \_\_no  \_\_unknown | Any documented, self-reported, or referred case of parent or caregiver who has a history of  abuse or neglect or has had involvement with child welfare services, either as a child or as  an adult. |
| History of substance  abuse or need for  treatment?  \_\_yes \_\_no  \_\_unknown | A history of substance abuse or need treatment by mother, father/partner, primary caregiver,  or anyone living in the household identified either by referral, self-report, or through a  substance abuse screening. |
| Are users of tobacco  products in the home?  \_\_yes \_\_no  \_\_unknown | Use of tobacco products by anyone living in the home identified either by self-report or  through a substance abuse screening. Tobacco use is defined as combustibles (cigarettes,  cigars, pipes, hookahs, bibis), non-combustibles (chew, dip, snuff, snus, and dissolvable), and electronic nicotine delivery systems (ENDS). |
| Have children at risk for,  or have low academic  achievement?  \_\_yes \_\_no  \_\_unknown | Based on self-report, enrollees who have perceived themselves or their child(ren) as having  low student achievement. Or mother or father/partner, or primary caregiver does not have  high school diploma or GED and /or children 18 younger living in the household are referred or  documented with risk for low academic achievement. |
| Have children with  developmental delays  or disabilities?  \_\_yes \_\_no  \_\_unknown | A child 18 years or younger living in the household having developmental delays or disabilities  documented or referred to Birth to 3, school early childhood programs, or medical records; or  suspected of having developmental delays or disabilities based on the Ages and Stages  Questionnaire (ASQ) or other screening processes. |
| Have family members  that are serving in armed  forces?  \_\_yes \_\_no  \_\_unknown | Documented or self-reported mother, father/partner, primary caregiver, or other individual is  a member (current or past) of any division of the armed forces and has a primary residence  with the family. |
| Pregnant woman over  age 21?  \_\_yes \_\_no  \_\_unknown | A current pregnancy occurring in a woman 21 years or older. |