Healthy Babies Referral Form

Date of Referral: _____

First Name: _____ **Middle Initial**: ____ **Last Name**: _____**Date of Birth**: _____

Street Address: _____ ____ **Apt**: _____**City**: _____ ___ **Zip**: _____

Phone: _____ **Message Phone**: _____ **Email**: _____

Attending School: ☐ YES ☐ NO **If yes, which school**: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Caucasian

☐ Native Hawaiian/Pacific Islander ☐ More than One Race ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Not Latino

Primary Language: ☐ English ☐ Spanish ☐ Other If Other please list: _____

Secondary Language: ☐ English ☐ Spanish ☐ Other If Other please list: _____

Interpreter Needed: ☐ YES ☐ NO **Do you have health insurance?** ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO **If yes, what is your due date?** _____

If not pregnant, what is your baby's date of birth? _____

How many times have you been pregnant? _____ **How many babies have you delivered?** _____

Are you under 18 years of age? ☐ YES ☐ NO **If yes, are your parents/guardians aware of this pregnancy?** ☐ YES ☐ NO

If pregnant; have you been to a doctor for this pregnancy? ☐ YES ☐ NO

What clinic provides medical care for you (pregnant) or your child (delivered)? _____

How did you hear about our program? _____

Notes/Comments: _____

_____

For Referral Source & Program Use Only

Referred by: ☐ Self ☐ Parent/Guardian ☐ Agency ☐ Friend ☐ Other If other, please list: _____

Referring Party Name _____ Phone: _____

Fax: _____ Email: _____

Please email, fax, or mail referral to: Healthy Babies ~ Sedgwick County Health Department

1900 E. Ninth St. N. ~ Wichita, KS 67214 ~ Phone: (316) 660-7433 ~ Fax: (316) 660-0997 ~ Email:

healthy.babies@sedgwick.gov **Revised June 2016**