Healthy Babies Referral Form

Referral Date:___________________________

Participant Name:____ **DOB (m/d/y):**__________ **Age:**______

Address:______________________________________ **Apt:**______ **City:**___________ **Zip Code:**__________

Phone # (xxx-xxx-xxxx):______________ **Other #:**______________ **School:**___________________________

Best time of the day to contact you (check all that apply): ☐ Morning ☐ Afternoon ☐ After School

Race (check one): ☐ Asian ☐ Am Indian/Alaska Native ☐ Black ☐ Caucasian ☐ Mid Eastern ☐ Other

Ethnicity (check one): ☐ Hispanic/Latino ☐ Non Hispanic/Non Latino

Language Spoken (check all that apply): ☐ English ☐ Spanish ☐ Other __________________________

Interpreter Needed: ☐ Yes ☐ No

Insurance (check all that apply): ☐ Medicaid ☐ Healthwave ☐ Medicare ☐ Private Insurance ☐ None

~~~~~~~~~~~~~~~~~~~~~~~~~~Pregnancy Information~~~~~~~~~~~~~~~~~~~~~~~~~~

Due Date:_______________ **# of Pregnancies (including this one):**________ **# of Deliveries:**__________

If mom is under 18 years of age, are her parents/guardian(s) aware of the pregnancy? ☐ **Yes** ☐ **No**

Has mom been to a doctor for this pregnancy? ☐ **Yes** ☐ **No**

Has the mom been informed about the Healthy Babies program/received a brochure? ☐ **Yes** ☐ **No**

Did the participant express interest in participating in the Healthy Babies program? ☐ **Yes** ☐ **No**

Special Needs or Concerns:____

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How did you hear about our program: ☐ **Brochure** ☐ **Door Hanger** ☐ **Magnet** ☐ **Website/Internet**

☐ **Friend or Family** ☐ **Other (please specify):**____

Referred by: ☐ **Self**

☐ **Someone Else (please specify):**

Name of person making referral:____

Agency:____

Phone Number:______________________ **Fax Number:**__________________________

Address & Zip Code:____

E-mail address:____

Please fax or mail referral to:

Healthy Babies – Sedgwick County Health Department
434 N. Oliver, Suite 110 – Wichita, KS 67208
316-660-7433 (phone) ~ 316-691-8473 (fax)
healthybabies@sedgwick.gov

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