# NURSE-FAMILY PARTNERSHIP REFERRAL FORM

| NFP Office Use Only |
|---|
| Record ID: ________ |
| Client ID: ________ |
| Revised 9/2010 |
| ________ |
| _____wks ___Days |
| AS OF |
| ________ |
| Turns 28 wks on ________Date |

**NOTE: To qualify for the Nurse-Family Partnership (NFP) Program, a woman must:**

- **Be less than 28 weeks pregnant (preferably by 16 wks or <)**
- **Have no previous live births(cannot have been issued a birth certificate)**
- **Be low-income**
- **Live in targeted area/county (Robeson Co.)**

An NFP nurse needs time to visit and obtain consent before the 28th week of pregnancy.

**Instructions:** Complete **Part 1** and **Part 2** of form. **Fax to (910) 608-2120**.
Please notify site if sending the referral via fax (HIPAA requirement).

**Referral Date: ____/____/____ Date Initial Contact Made: ____/____/____(NHV)**

**Part 1**

## Client Information: Medicaid: □Yes □No/Private Ins: □Yes □No/Family Income:

Leave Family Income Blank If Medicaid

| Name: | | Age: | Birthdate / / | # of weeks Pregnant: |
|---|---|---|---|---|
| Confirmed with Pregnancy Test? □ Yes , Date / / □ No | LMP: / / | Expected Delivery Date: / / | Speaks English? □ Yes □ No | If No, Specify Language: |
| Physical Address: | Apt: | May contact by phone □Y□N | May contact by mail □Y□N | Best time to call ________ |
| City: | State/Zip: | Risk Factors: | | |
| Home Phone #: | Work Phone #: | Cell Phone #: | | |

| Emergency Contact Person: | Relationship to Patient/Client: | Contact's Home Phone #: | Work Phone #: | Cell Phone #: |
|---|---|---|---|---|

□By checking this box you give permission for NFP to speak with the emergency contact listed above concerning you or our program

| Client agrees to be referred to NFP & provide the information above regarding her pregnancy: □ Yes □ No | Client's Signature: | Date: / / |
|---|---|---|

**Part 2**

## Referring Agency/Practice Information

| Agency/Practice Name, Facility or Division & Address | Date: / / |
|---|---|
| Referring Staff Name: | Title: |

**Part 3**

## To Be Completed by the Nurse-Family Partnership Site

**Referral Source:** □ 1. WIC □ 2. Pregnancy Testing Clinic □ 3. Healthcare Provider/Clinic □ 4. School □ 5. NFP Client (current/past) □ 6. Other home visitation program □ 7. Medicaid □ 8. Self □ 9. Other (includes other human service agency)

**Disposition of Referral:** □ 1. Enrolled in NFP □ 2. Refused participation □ 3. Unable to locate □ 4. Did not meet NFP criteria □ 5. Did not meet local criteria □ 6. Program full □ 7. Already enrolled in another program □ 8. Unable to serve due to language
If ineligible: □ >28 Weeks Pregnant □ Previous Live Birth □ Unable to Locate □ Other: (Specify)

Contact Log:


**Robeson County Department of Health**
**460 Country Club Road**
**Lumberton, NC 28358**
**(910) 671-3225; (910) 671-3224; Fax (910) 608-2120**

☐ Keyed in ETO referrals ☐ Dismissed from referrals ☐ Dismissed from ETO/NFP ☐ Enrolled in NFP