BC Family Health Visiting Program:

Referral Form

Date of referral (dd/mm/yyyy): ______________________________

Client Information

First name: ____________________________ Last name: ____________________________________

Preferred name (if different): _________________________________ Parent less than 25 years old ☐

Personal Pronouns:

☐ She/Her ☐ He/Him ☐ They/Them ☐ Client prefers not to answer ☐ Unknown

☐ Personal pronouns (other): ____

Consent to Referral

The client is aware of this referral and consents to being contacted by Public Health:

☐ Yes ☐ No *(If no, do not submit this form)*

Address Information

What is the best address to contact the client within the next 4 weeks?

____

Contact Information and Preferences

Preferred phone number: ____________________ ☐ Cell ☐ Home ☐ Other ☐ No phone

Alternate phone number: ____________________ ☐ Cell ☐ Home ☐ Other

Email address (optional): ____

E-mail addresses are used for the purpose of communicating with clients and sharing resources.

Preferred contact method(s):

☐ Phone ☐ Safe to leave voicemail ☐ Text ☐ Safe to leave text message ☐ Email

Best time to contact (optional): ____

Alternate contact person (if applicable):

Name: ____ Phone: __________________

Is a language interpreter required? ☐ Yes ☐ No

Spoken language: ____

Preferred written language (if different): ____

Other communication or accessibility needs or preferences:

____

Pregnancy Information (if applicable)

Currently pregnant? ☐ Yes ☐ No If yes, EDD (dd/mm/yyyy): ____________________

Name of doctor, midwife or nurse practitioner: ____________________

☐ Client does not have a primary care provider

Clinic name (if applicable): ____________________

Clinic phone number: ____________________ Clinic fax number: ____________________

Parenting Information

Is client parenting an infant or young child? ☐ Yes ☐ No If yes, age(s) of child(ren): __________

Referral and Support Information

Pregnancy and/or parenting support topics of interest to the client (check all that apply):

- ☐ Prenatal, postpartum, or general parenting support
- ☐ Strengthening relationship with infant/child
- ☐ Relationships and/or safety for self or family
- ☐ Social connection, cultural, and/or community supports
- ☐ Mental health and wellness
- ☐ Current experiences with substance use (regulated and unregulated)
- ☐ Housing, financial, or food supports
- ☐ Other: ____________________

Strengths and resources current, or anticipated, that support their parenting role (check all that apply):

- ☐ Strong social and/or cultural support network
- ☐ Access to transportation
- ☐ Stable living conditions (housing, employment or finances)
- ☐ Education/training
- ☐ Other ____________________

Additional details (optional):

Referral Source

- ☐ Registered Midwife
- ☐ Family Physician
- ☐ Nurse Practitioner
- ☐ Registered Nurse
- ☐ Community-Based Organization
- ☐ Other: ____________________

Referring person's name: ____________________

Phone number: ____________________

Organization if applicable: ____________________

Address:

Office email: ____________________

Fax number: ____________________

Would you like to be notified about the outcome of this referral? ☐ Yes ☐ No

Consent for Methods of Communication

(Regional health authority disclosure statement)

Signatures

This consent is not valid unless signed and dated.

Referring Person's Name (print): ______________________ Date (dd/mm/yyyy): __________

Signature: ____

Interpreter Declaration *(if applicable)*

I confirm that I have explained the nature and purpose of this consent to the above-named client (and/or legal substitute decision maker) in their preferred language.

Interpreter Name (print): ____________________________________

Interpreter ID: ____________________ Organization: ______________________

Signature: ______________________________ Date (dd/mm/yyyy): __________

What Happens Next?

- A Public Health team member will try and contact you within XXX business days.
- Available support and next steps will be discussed.
- **Participation in services is voluntary, and you can withdraw or decline services at any point of your pregnancy or parenting journey.**

Send completed referrals to:
Phone: (XXX) XXX-XXXX or
Fax: (XXX) XXX-XXXX or
Email: XXXXXX