Recomendación al Programa NFP

Favor de llenar este formulario y lo mandaran por email o FAX a la Asociación de Familias y Enfermeras de BCHHS – Nurse Family Partnership
nfpreferral@buncombecounty.org 828-250-6095
Please complete this form with the client and email or fax to BCHHS-Nurse Family Partnershipnfpreferral@buncombecounty.org 828-250-6095.
Favor de marcar 828-250-5063 con cualquier pregunta/ problema. Please call 828-250-5063 with any questions/problems.

Consentimiento de Cliente/ Client Consent

Doy mi consentimiento voluntariamente para mandar una recomendación al programa NFP de mi parte.
I voluntarily consent to having a referral sent to the NFP program on my behalf. ____
Firma del cliente/padre o madre/ Persona responsable legalmente Signature of Client / Parent / Legally Responsible Person

Doy mi consentimiento voluntariamente para que el programa de NFP comparte mi estatus de inscripción con la agencia dando la recomendación.
I voluntarily consent for the NFP program to share my enrollment status with the referring agency.____
Firma del cliente/padre o madre/ Persona responsable legalmente Signature of Client / Parent / Legally Responsible Person

(La agencia hacienda la recomendación será notificada dentro de 30 días después de la fecha del consentimiento dado por el cliente.)
(The referring agency will be notified of the client referral outcome within 30 days when consent is provided by the client.)

Información del Cliente/Client Contact Information

Fecha de la Referencia: Date of Referral:	Nombre First Name:	Apellido / Last Name:
Fecha de Nacimiento DOB:	Fecha de Alivio/ EDD:	Cuidado Prenatal Prenatal Provider:
Raza/ Race:	Etnicidad/ Ethnicity:	Idioma Principal Primary Language:
Domicilio: Street Address:		Ciudad/Estado/Código Postal City/State/Zip Code:
Número Telefónico: Phone Number:	Mejor Hora para Llamar: Best time to call:	¿Se puede dejar un Correo de Voz? Can a message be left?
Persona(s) Designadas y/o Número(s) Alternativos Alternative Contact Person(s) and/or Numbers(s):		

Referral Criteria

- ☐ Client is a primip - Client's first pregnancy or client has had no previous live births. Client is low income (qualifies for Medicaid, Food Stamps and/or WIC) and client is currently less than 29 weeks gestation.
- ☐ Client is a multip – Client has had one or more previous live births. Client is low income *(qualifies for Medicaid, Food Stamps and/or WIC)*; client is currently less than 29 weeks gestation; client has not participated in more than 8 home visits with a NFP program in the past.

Referral Source

Primary Referral Source Name: ____ Phone number: ______________________________
Referral Agency Program Name: ____

For NFP Agency Use Only: Client Risk Factors	
☐ Previous preterm birth ☐ Previous low birth weight baby ☐ Currently homeless ☐ Mental health diagnosis or concerns ☐ Recent history or current substance use ☐ Previous or current involvement with child welfare	☐ History or current intimate partner violence ☐ Less than high school education or GED ☐ 19 years or younger ☐ Developmental disabilities ☐ Medical conditions requiring MD management ☐ Other concerns ______________________________
Client met NFP referral criteria for Primip Program ☐ Yes ☐ No	
Client met NFP referral criteria for Multip Program ☐ Yes ☐ No	