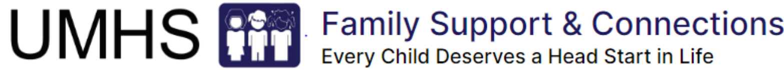
| **Umatilla County** | **Morrow County** |
| --- | --- |
| **Fax:** 541-278-5433<br>**Call:** 541-278-5432<br>**Email:** health@umatillacounty.gov | **Fax:** 541-676-5652<br>**Call:** 541-676-5421<br>**Email:** health@umatillacounty.gov |




# Prenatal, Maternal, and Child Services Referral

This is a shared referral form: ANY client referred will be connected to the appropriate Public Health or UMHS program available in their county. Thank you for joining with us to serve our community!

Nurse Family Partnership    Babies First!    CaCOON    Early Head Start/Early Head Start Classroom

Yellowhawk/Átawišamataš    Early Head Start/ Head Start Home Visiting    Family Support & Connection

WIC    OHP

**Today's date**:_______________________ **EDD** (Estimated Delivery Date):__________________

**Person being referred**:_______________________________**DOB**: ________________________

Parent/Guardian name (if child):_________________________________________ Relationship:________________

**Home Phone**: (    )____________________**Cell Phone**: (    )________________________

**Home Address**:__________________________________ **City, State, Zip**:___________________

**Primary Language** (circle one): English Spanish **Tribal Member:** YES / NO

**Client Consents to be contacted by any of the above programs: YES / NO**

## Please check all that apply:

- ☐ 1st pregnancy
- ☐ Newly pregnant needing assistance
- ☐ Teen parent
- ☐ Child with/at risk for developmental delays
- ☐ Parent with developmental delays
- ☐ Lack of adequate parenting skills
- ☐ Infant feeding/weight gain issues
- ☐ Challenging child behaviors
- ☐ Risk of maternal depression
- ☐ Isolation/lack of support
- ☐ Lack of client/patient follow through
- ☐ Domestic violence (present or history of)
- ☐ Tobacco/alcohol use
- ☐ Substance abuse- *describe below*
- ☐ Other-*describe below*
- ☐ Medical Condition:_______________________

**Additional Info:**__________________________________________________________________

**Referring Source Information:**

Organization/Department: _______________________________________________

Person/Provider submitting referral:_____________________________________________________

Phone Number:(    ) ______________ Fax Number: (    )______________ Email:__________________

**Do you need follow up information about client's enrollment into services? Yes ☐ No☐**

April 2024

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UMHS Family Support & Connections
Every Child Deserves a Head Start in Life

# RESPONSE to Referral:

Referral assigned to:

Nurse Family Partnership   Babies First!   CaCOON   Early Head Start/Early Head Start Classroom
Yellowhawk/Átawišamataš   Early Head Start/ Head Start Home Visiting   Family Support & Connection
WIC   OHP

Please contact referral partner listed below for further follow up:

Organization/Department: ____________________________________________

Person/Provider assigned to client: ____________________________________________

Phone number:__________________________ Fax number:____________________________________

Notes:________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________