Referral Phone: 301.431.6210

Fax: 301.431.6212

Email: [healthyfamilies@pgcrc.org](mailto:healthyfamilies@pgcrc.org)

|  |  |
| --- | --- |
| **Referral Site:** | **Date Screen Completed:** |
| **Phone:** | **Email:** |

CLIENT INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **DOB:** | | **EDD:** |
| **Infant Name/ DOB if already born:** | | | |
| **Address:** | | | |
|  | | | |
| **Phone Number:** | | **Email:** | |
| **Primary Language:** | | **Other Language Spoken:** | |
| **Parent/Guardian Name:** | | **Phone Number:** | |
| **Baby’s Father Name:** | | **Phone Number:** | |
| **Ethnicity:**  **Hispanic/ Latino**   **Not Hispanic/ Latino** | | **Race:**  **African American**   **African**   **Asian/ Pacific Islander**   **Native American/ Alaskan**   **Caucasian**   **Multi-racial**  **Other** | |
| **First Time Mother:**  **Yes**  **No High Risk Pregnancy?**  **Yes**  **No** | | | |
| **Reason for Referral/ Comments:** | | | |

FAMILY SCREEN

Determine if each of the following statements is, True, False or Unknown. Please put an X in the corresponding column.

**The screen is positive if #1, 9 or 12 are True; any 2 items are True; there are 7 or more Unknowns.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **T** | **F** | **U** |  |  | **T** | **F** | **U** |
| **1** | Single, Separated, Divorced, Widowed |  |  |  | **9** | Late prenatal care, no prenatal care, poor compliance |  |  |  |
| **2** | Partner Unemployed |  |  |  | **10** | History of abortions |  |  |  |
| **3** | Inadequate income or no information regarding source of income |  |  |  | **11** | History of psychiatric care |  |  |  |
| **4** | Unstable housing |  |  |  | **12** | Abortion unsuccessfully sought or attempted |  |  |  |
| **5** | No phone |  |  |  | **13** | Relinquishment for adoption sought or attempted |  |  |  |
| **6** | Education under 12 years |  |  |  | **14** | Marital or family stresses |  |  |  |
| **7** | No emergency contact (Do not include immediate family) |  |  |  | **15** | History of, or current, depression |  |  |  |
| **8** | History of substance abuse |  |  |  | Total |  |  |  |  |

Is client receiving services with another agency? Yes No Unknown Name and contact:

**FAMILY CONSENT:** Client gave verbal consent to be contacted by Healthy Families Staff Program?  Yes  No (**Exception:** if the client is under 14 years old, parental authorization will be needed).

