The CHILD Project:
ROAD TO RESILIENCE
YOUR PARTNER IN PARENTING

Referral form

Instructions: Please complete this form by checking the box that best fits the client's situation at the time of referral. If you don't know the information needed to check a box, leave all the boxes blank. Client's name and contact information must be included to process the referral. Send completed form to the R2R Project Manager via email at anns@communicarehc.org or via fax to (530)-204-5248.

Referring Party:

Date of Referral:________________________________ **Referral Agency:**____

Referring Person:_______________________________ **Phone/Email:**____

Referral Discussed with Client: Yes ☐ No☐

Client's Contact Information:

Client's Name:____ **DOB:**________________ **Gender:**____________
(Last) (First)

Address:____
(Street) (City) (Zip)

Phone:__________________________________ **OK to text?** Yes ☐ No☐ **OK to leave voicemail?** Yes ☐ No☐

Preferred Language: _________________________ **English Interpreter Needed?** Yes ☐ No☐

Client's Health Information:

Pregnancy & Parenting: Currently Pregnant? Yes ☐ No☐ If yes, due date:___________________________________

Week started prenatal care with current/most recent pregnancy: <14 weeks ☐ 14-27 weeks ☐ 28+ weeks/none ☐

Number of Children:___________ Age(s) of Children:____________________ Children Live with Client? Yes ☐ No☐

Tobacco Use/Vaping: None ☐ Secondhand Smoke Exposure ☐ Client Currently Uses Tobacco/Vapes ☐

Substance Use/Abuse: No Substance Use History ☐ Has Used Cannabis/Illicit Drugs/Alcohol in Last 2 Years ☐

Currently Enrolled in Treatment Program ☐ Substance Use in Last 30 days, Not Enrolled in Treatment Program ☐

Reason for Referral::

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