Nurse-Family Partnership
Helping First-Time Parents Succeed

Referral Form

Date: _____

To: Nurse-Family Partnership

□ Skagit County Public Health (FAX: 360-416-1501) (PHONE: 360-416-1523)

From: Name: _____

Phone: _____

Re: **The following client would like to be contacted to receive more information about the Nurse-Family Partnership Program.**

Eligibility: □ First-time mother □ Apple Health/WIC eligible □ Less than 28 weeks gestation

FAMILY INFORMATION:		
Client's Name [PRINT CLEARLY]	Date of Birth	Estimated Due Date
Address [INCLUDE Apt # and zip code]	Primary Contact Number	Message Number
Primary Spoken Language: **English ☐** **Spanish ☐** **Mixteco ☐**		
OK to Text or Email? YES ☐ NO ☐	OK to Leave a Message? YES ☐ NO ☐	
Email [PRINT CLEARLY]		
Is client **First**-time mother? YES ☐ NO ☐	Is client enrolled in WIC? YES ☐ NO ☐	
Client Consent for Referral: I give my permission to share the information on this referral form with the agency selected, above. If a referral is made, I understand that I may be contacted by program staff. I authorize the referral agency to use the information on this form to help me get the services that I am requesting. _____ Client Signature		