**ESC Logo 2Early Success Coalition Network**

**Client Referral Information**

**FAX to 901-287-4701 Attention: Early Success Coalition**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date: | / / | Agency: |  | Staff Name: |  |

|  |  |
| --- | --- |
| Preference of location to receive services: | 🞏 Clinic/Center 🞏 In-home Services 🞏 Faith-based Services |

**Section One – General Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Name: | |  | | | | | Age: | |  | | | | | Race: | | |  | |
|  | | Last Name, First Name | | | | |  | | | | | | | | |  | | |
| Address |  | | | | City: |  | | | | Zip: | | |  | | Home Phone:\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| Cell Phone: |  | | | | Other Phone: | | | | | |  | | | | | | | |
| Insurance Type: | | | 🞎 Private 🞎 TennCare 🞎 None 🞎 Other (specify): | | | | | | | | |  | | | | | | |
| Primary Language: | | | | 🞎 English 🞎 Spanish 🞎 Other (specify): | | | |  | | | | | | | | | | |

**Section Two: Prenatal Screening Only**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is this your first pregnancy or previous pregnancy did not result in a live birth? | | | | | | | | | 🞏 Yes 🞏 No | | |
| Number of weeks pregnant | |  |  |  | | | Expected Due Date: | | | / / | |
| Number of weeks pregnant at 1st prenatal visit:\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 🞏 No prenatal care | | | | | |
| **Current Health Concerns or On-going Medical Problems: (*check all that apply*)** | | | | | | | | | | | |
| 🞎 | High Blood Pressure/Hypertension | | | | 🞎 | | | Diabetes (during pregnancy) | | | |
| 🞎 | Mental Health Diagnosis | | | | 🞎 | | | High Cholesterol | | | |
| 🞎 | Previous Low Birth Weight/Preterm Delivery | | | | 🞎 | | | Other Health Concern: (specify) | | |  |

**Section Three: Post-natal Screening Only**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Infant Name: | |  | | Age: | | |  | | Gender: | 🞏 Male 🞏 Female | |
|  | | Last Name, First Name | |  | | | | | | | |
| **Current Health Concerns or On-going Medical Problems for Child: (*check all that apply*)** | | | | | | | | | | | |
| 🞎 | Premature (born < 37 weeks pregnant) | | | | 🞎 | Low Birth Weight (born less than 5.5 lbs/2,500 grams) | | | | | |
| 🞎 | Asthma or Other Respiratory Issues | | | | 🞎 | Developmental Delay | | | | | |
| 🞎 | Special Health Care Need (i.e. congenital anomalies): (specify) | | | | | | |  | | | |
| 🞎 | Other Health Concern: (specify) | |  | | 🞎 | None | | | | |  |
| **Current Health Concerns or On-going Medical Problems for Mother: (*check all that apply*)** | | | | | | | | | | | |
| 🞎 | High Blood Pressure/Hypertension | | | | 🞎 | Diabetes (during pregnancy) | | | | | |
| 🞎 | Mental Health Diagnosis | | | | 🞎 | High Cholesterol | | | | | |
| 🞎 | Other Health Concern: (specify) | |  | | 🞎 | None | | | | | |

**Section Four: Provider Selection (in order of client’s preference)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. |  | |  |  | |
| 2. |  | | | |  |
| 3. |  |  | |  | |

I authorize the exchange of my health information, as recorded above, with the agencies of the Early Success Coalition Network, i.e. HUGS, Healthy Families, Nurse-Family Partnership, One-to-One, First Steps, Neighborhood Christian Center, Parents as Teachers, Operation Smart Child, Early Head Start, Centering Pregnancy and Parent Aide for the purpose of providing services based on my eligibility and choice. This authorization remains in effect until revoked in writing by me.

**Participant Signature:**  **Date:**