



Nurse-Family Partnership Clark County Public Health Referral Form

NOTE: To qualify for the Nurse-Family Partnership (NFP) Program, a teen/woman must:

- Be less than 28 weeks pregnant (please refer as early in pregnancy as possible)
- Have no previous live births
- Be low-income
- Live in Clark County

Instructions: Complete **Part 1** and **Part 2** of form. Mail or fax to Clark County Public Health, Nurse Family Partnership Program, and please let us know by phone to expect the referral (HIPAA requirement). Fax: (360) 397-8442 Phone: (360) 397-8440

Date: ____ / ____ / ____

Jan. 2014

Part 1 Patient/Client Information

Last Name:		First Name:		Age:	Birthdate / /	
Expected Delivery Date: / /		28wks Gestation on: / /		Primary Language:		Interpreter Needed Y N
Address:			Apt:	City:		Zip:
Home Phone #:	Work Phone #:	Cell Phone #:		Message #:	Texting: Y N	
Email address:			Medicaid/Provider One #, if available:			
Patient agrees to be referred to NFP & provide the information above regarding her pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No				Patient's/Client's Signature:		Date: / /

Part 2 Referring Agency Information

Agency/Practice Name:		Medical Provider Name:		Date: / /	
Address:					Zip:
Referring Staff Name:			Title:	Phone #:	
Feedback desired, related to outcome of referral? Y N			Fax #:		

Part 3 To Be Completed by the Nurse-Family Partnership Site

Referral Received By: _____	Referral Assigned to: _____
Disposition of Referral:	
<input type="checkbox"/> 1. Enrolled in NFP Program	Date of Enrollment: ____ / ____ / ____
<input type="checkbox"/> 2. Ineligible: <input type="checkbox"/> >28 Weeks Pregnant <input type="checkbox"/> Previous Live Birth <input type="checkbox"/> Unable to Locate <input type="checkbox"/> Other, Specify:	
<input type="checkbox"/> 3. Declined Participation in NFP <input type="checkbox"/> Yes <input type="checkbox"/> No If Declined, Reason:	
Comments:	
Completed by NFP Staff:	NFP Site:
Date: ____ / ____ / ____	

