

*Caregiver/Adult's name: _____

*Date of activity: ____/____/____

*Reason(s) for visit: (Select all that apply)

Mental Health

- Thinking about hurting self
- Feeling of guilt/being let-down

Substance Use/Addiction

- Past substance use problem
- Current substance use problem
- Smoked in past week
- Household smoker

Interpersonal Violence

- Recently physically hurt by other
- Afraid of partner/other

Parenting

- Lose control when disciplining child
- Kids with medical/special needs

Infant Health/High Risk Pregnancy

- Baby born 3 or more weeks premature
- Baby weighed less than 5lbs, 8oz
- Baby not born alive
- Baby died within 1st year

Financial Assistance

- No reliable source of income
- Can't afford monthly bills
- Can't afford food
- Home in bad condition
- Safe, stable place to live
- Reliable transportation
- Behind in rent/mortgage

Other

- Deployed/returned home
- Other: _____

*Date of referral: ____/____/____

*Reason for referral:

*Date of appointment: ____/____/____

*Date patient was notified of appointment: ____/____/____

Additional Notes: _____
