Revised 3.20.17

HEALTHY BEGINNINGS - ENTRY AGENCY REFERRAL:

____PREGNANT MOM Expected Delivery Date: ___/___/____	____CHILD (0-age 5) Child's Birth Date: ___/___/____
PHONE REFERRAL TO HMHB 1-888-414-4642	**HOME SAFE TELEPHONE# 1-561-383-9800**
FAX REFERRAL TO HMHB: 561-840-4046	**FAX REFERRAL TO Home Safe: 561-383-9859**

PARTICIPANT'S CONTACT INFORMATION:

Targeted Participant Name: _____

Participant's Date of Birth: ____/____/_____ Gender: M F Participant's Phone #: ____-_____-_____

Alternative Phone #: ____-_____-_____ (Relationship to participant): _____

Home Address: _____ City _____Zip Code: _____

Language(s) spoken: ____English ____ Spanish ____ Creole ____Other (Describe):_____

Name of Parent/Guardian (if participant is under age 18): Relationship to Participant:

REASON FOR REFERRAL:

____Suspected developmental delay or concern of child (Please circle areas of concern):

Behavior Motor/Physical Cognitive Social/Emotional Speech/Language Other _____

____Pregnant Mom Is this the client's 1st child? Y / N Estimated Date of Delivery: ____/____/_____

____Unsafe Sleep ____Parenting ____At Risk (Describe risk factors): _____

____Other (Describe): _____

REFERRAL SOURCE CONTACT INFORMATION:

Person Making Referral: _____ Date of Referral: ____/____/____

Agency/Program: _____ Supervisor: _____

Contact Phone#: ____-_____-_____ Fax#: ____-_____-_____

Best way to contact client (date, time& location): _____

After initial appointment, please send the following information back to me:

___Contact information of assigned service coordinator _____ Screening Status – Delayed/At-risk: _____Yes _____No

Child/Family referred to: Healthy Beginnings _____Community Resources _____None _____

Other (Describe): _____

RELEASE OF INFORMATION CONSENT:

I, _____(print name of participant or child's legal guardian), give my permission for _____ (person making referral), to share any and all pertinent information regarding me or my child, _____ (print participant's name) with the Healthy Beginnings Entry Agency listed above, the Referring Agency, as well as the Children's Services Council of Palm Beach County for administrative, fiscal, evaluation, audit purposes, and/or to ensure provision of quality services. This authorization shall remain in effect unless withdrawn in writing. Please see reverse side for withdrawal of consent.

Signature: _____ Date: _____

(____Participant or ___ child's parent/legal guardian)

This form will expire 60 business days from date of signature.

FOR ENTRY AGENCY USE ONLY:

DATE REFERRAL RECEIVED: ____/____/____ **DATE OF INITIAL CONTACT:** ____/____/____

1st contact attempt: ____/____/____ **2nd contact attempt:** ____/____/____ **3rd contact attempt:** ____/____/____

Outcome of Referral: _____

Name of Assigned Service Coordinator: _____ **Phone #:** ____-_____-_____

Name of Supervisor: _____ **Phone #:** ____-_____-_____

Targeted Participant Name: _____

Participant's Date of Birth: ____/____/_____ Gender: M F Participant's Phone #: ____-_____-_____

Alternative Phone #: ____-_____-_____ (Relationship to participant): _____

Home Address: _____ City _____ Zip Code: _____

Withdrawal of Consent:

By signing below, I withdraw my consent to participate in services at this time. I understand that withdrawing my consent does not stop information sharing that has already happened. Withdrawing my consent will not affect future care if I decide to seek services in the future.

_____	_____	_____
Participant's Signature	Participant's Printed Name	Date

Reason for withdrawal (optional) _____