Comanche County Health Department

2015 Combined Referral

parentPRO
Free parenting support. Delivered to your door.

Today's Date: _____

Referral Organization: _____ Referrer's Name: _____

Last Name: _____ First Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip Code: _____ County of Residence: _____

Email: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Language: ☐English ☐Spanish ☐American Sign Language ☐Other Disability: ☐Blind ☐Deaf ☐None ☐Other ☐Wheelchair

Referral Source:

☐ WIC	☐ Current/Past Client	☐ Health Dept. Family Planning	☐ Faith-Based Organization
☐ DHS	☐ Self-Referral	☐ Health Dept. Maternity	☐ Parent Pro
☐ IHS	☐ Private physician	☐ Other pregnancy testing clinic	☐ Community Connector
☐ School	☐ Judicial System	☐Food Stamps	☐ Hospital
☐ TANF	☐ Baby Line	☐ HMO/Health Care Plan	☐ Other:_____

Marital Status: _____ Gender: ☐M ☐F Race Category: _____ Ethnic Category: ☐ Hispanic ☐Non- Hispanic

Are you currently enrolled in school? ☐Yes ☐No Last Grade Completed: _____ Time of Screening: ☐Prenatal ☐Postnatal

Are you or will you be a first time parent? ☐Yes ☐No If no, how many children do you have? _____

Expected Date of Delivery: _____ Number of weeks pregnant: _____

Date of 28 Weeks: _____ Number in family (include pregnant woman = 2 people): _____

Annual Household Income: $ _____ What is the date of your baby's birth? _____

If your baby is already born, does the baby have any birth defect or developmental concerns (ex. prematurity)? ☐Yes ☐No

Is the referred individual comfortable being contacted at home by a Parent Pro employee?
☐Yes, by phone only
☐Yes, by mail only
☐Yes, by phone OR mail
☐No. for Instructions contact: _____

If the referred individual is not home, can the caller leave a message with other people who answer?
☐Yes – Anybody or on answering machine
☐ Yes– Specific person(s) (First name(s): _____
☐ No. Do not leave a message.

_____ _____
Referrer's Signature: Date: