For Office Use Only

45-day Date _____

IFSP Date _____

THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

REFERRAL to: UNM *FOCUS* PROGRAM

PHONE 505-272-3459~FAX 505-272-3461

Referral Source: _____ *Phone* _____ *Date* _____
(Name & Agency)

Has family been referred to any other EI Program (RCI, PB&J, Alta Mira, etc) _____
(Agency Name)

If Parent is the referral source, how did they learn of our program? _____
(Name& Agency)

Child's Name _____ DOB _____ Male/Female MR#_____

Child's SSN#_____ Medicaid **Y N** #_____

Address:_____ City: _____ State:_____ ZIP:_____

Telephone(s): _____ □ H □ Cell □ Wk Primary Language _____

Baby's Race/Ethnicity: □ Asian □ Caucasian □ Black □ Hispanic □ American Indian –Tribe_____

Caregiver's Name _____ Relationship _____ Primary Contact **Y N**

DOB _____ MR#_____

If alternate care, relationship to child _____ Primary Contact **Y N**

Partner's Name _____ FOB? **Y N** Partner Positive Influence? **Y N**

Family Size:_____ Children living in home (include DOB or age. Check those believed drug exposed):

1. _____ 2. _____ 3._____

School District _____

Others living in the home (indicate relationship):_____

ID# _____ Birth Wt _____ Gestational Age:_____ Apgars:_____ G:____ P:____

Prenatal Care: _____ Breast Feeding: **Y N**

Drug Exposure:_____

Infection or chronic illness (HIV, Hep B or C, etc.):_____

	Mother	Baby
Toxicology:		
Substance:		

Child's doctor:_____ at:_____

Next WCC Appt:_____ Insurance:_____

Caregivers Employment:_____ how long?_____

Benefits Received: ☐ Medicaid ☐Cash Assistance ☐Food Stamps ☐ WIC ☐Commodity

Baby's Basic Needs Met: ☐ Baby Clothing ☐ Diapers ☐ Formula ☐ Car Seat

Current or history of involvement with Child Protective Service:_____

_____

PLAN:_____

_____

Reasons for Referral, Check all that apply, including family history of

- ❒ Relative Caregiver_____
- ❒ Substance Use Concerns (specify)_____
- ❒ Prenatal Exposure (specify)_____
- ❒ Mental Health Problem (specify)_____
- ❒ Domestic Violence_____
- ❒ Teen Parent_____
- ❒ Premature Infant (gestational age)_____
- ❒ Developmental Concerns_____
- ❒ Parenting _____
- ❒ Medical Care for Child _____
- ❒ Medical Care for Caregiver _____
- ❒ Developmental Monitoring of Child _____
- ❒ Legal Services _____
- ❒ Basic Needs not met _____
- ❒ Other _____

Comments:

RELEASE OF REFERRAL INFORMATION

I _____ , agree to let _____ , share information about me with the UNM *FOCUS* programs so they can contact me about participating in the UNM *FOCUS* programs. I understand that this information will remain strictly confidential and that I am under no obligation to participate in the UNM *FOCUS* programs.

_____ _____

Signature *Date*

I also agree to let _____ fax this Release of Information Form.

_____ _____

Signature *Date*

Other Contact Person (someone who would know how to reach you):

Name _____

Address _____

Phone(s) _____