HASTINGS PRINCE EDWARD
Public Health

Healthy Families Referral
Fax to: 613-966-4363

Date: ______________________________

Referrer information (if applicable)
Please enter the contact name and name of the agency/health care provider submitting the referral.

Contact name ____

Agency ____

Client Information

Client name * ______________________________ **Client date of birth** * ________________
yyyy – mm - dd

Address * ____

City * ______________________________ **Postal Code** ________________

Phone * ______________________________

Referral type *

O **Prenatal** EDD: ________________
yyyy - mm - dd

- -

O **Postpartum** (0-6 weeks)
If Known: Gestational Age: _____ wks. Baby's DOB: ________________
yyyy - mm - dd

** Reason for Referral*

☐ Breastfeeding ☐ Infant Feeding ☐ Postpartum Depression/Anxiety ☐ HBHC

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O **Early Childhood** (6 weeks to 3-8 years)
** Reason for Referral*

☐ Breastfeeding ☐ Postpartum Depression/Anxiety ☐ HBHC
☐ Positive Parenting ☐ Growth and Development

Client consent *

The client has given permission for this form to be sent to the Hastings Prince Edward Counties Health Unit so that a public health nurse can contact them regarding the Healthy Families programs and, if necessary, communicate with your health care provider. They understand the Health Unit will keep their information confidential and will use it for the purpose of administering the programs.

☐ **Client Consent Obtained**