HASTINGS PRINCE EDWARD
Public Health

Healthy Families Referral
Fax to: 613-966-4363

If you have immediate concerns about your client's health or the health of their baby, please encourage them to contact their health care provider. If they do not have a health care provider, they may contact Health811, available by phone 24/7 at 811, or a walk-in clinic. For urgent medical emergencies, please contact 911 or visit the local Emergency Department.

*** Indicates a required field.**

Date: _____

Referrer Information:

Agency Name: _____

Contact Name: _____

Phone Number: _____

Client Consent:

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

☐ **Client consent obtained/provided ***

Parent/Caregiver Information:

First name* _____ **Date of birth *** _____
yyyy – mm - dd

Last name* _____ **Preferred Pronouns** _____

Address * _____

City * _____ **Postal Code** _____

Email _____

Phone * _____

Please confirm the owner of the phone number provided:

- ☐ *Client's personal phone*
- ☐ *Client's partner's phone*
- ☐ *Client's parent's phone*
- ☐ *Other (please specify): _____*

☐ Client consents for a Healthy Families Program staff member to leave voice messages, send a text and/or email at phone number/email provided above. We may need to connect with the client to facilitate service.

Pregnancy/Child Information:

If pregnant, estimated due date: _____ (yyyy - mm – dd) **Previous parenting experience?** ☐ **Yes** ☐ **No**

Child's date of birth *(if parenting)* _____ (yyyy - mm – dd) ☐ **M** ☐ **F**

First and last name of child *(if parenting)* _____

Reason for Referral:

☐ **Home Visiting Programs**

☐ **Parental Mental Health Support**

☐ **Breastfeeding/Infant Feeding Support (specify below)**

☐ Latch/suck problems ☐ Milk production concerns ☐ Baby not satisfied

☐ Nipple shield use ☐ Inadequate weight gain ☐ Bottles/formula

☐ Nipple/breast pain ☐ Previous breast surgery ☐ Needs support

Birth Weight: _____ Gestational Age: _____

**Some of our programs have eligibility criteria. A public health nurse will contact the client to gather further information and to offer the service(s) that best meet their needs.

Comments/Additional Notes:

_____

_____

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We are committed to providing accessible publications, programs, and services to all. For assistance please call 613-966-5500; TTY: 711 or email at accessibility@hpeph.ca. For more information, please visit hpePublicHealth.ca

The personal information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, Chapter H.7, and will be used for assessment, management, treatment and reporting purposes. Questions concerning this collection of personal information should be directed to the Privacy Officer at 179 North Park Street, Belleville, Ontario K8P 4P1 613-966-5500.