INFANT CHILD ENRICHMENT SERVICES
RAISING HEALTHY FAMILIES REFERRAL FORM

Fax Number: 533-4017 Phone Number: 533-0377

Recommended Services:

___In-home parenting education/support

___Parenting classes:
Required #? ___ *Required Topic?:*_____

___Differential Response __*Path 1* __*Path 2*

Name of referring person: _____

Name of referring agency: _____

Phone Number: _____

Email address: _____

Referral Date:_____

FAMILY INFORMATION:

Name of Parent(s):_____ Phone number:_____

Physical Address:_____

Name of child	Birth date	Ethnicity	Disabilities
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____

REASON FOR REFERRAL/STATEMENT OF FAMILY NEEDS:
(Please describe any concerns you have and what areas of parenting you would like us to focus on)

_____

_____

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_____

_____

For RHF USE ONLY:
DATE OF INTAKE:_____
Signed up for: In-Home _____
Classes:_____ Other: _____
Assigned to: _____

Type of referral:
___ Self-Referred
___ SELF program
___ School: _____
___Other Community Partner:_____
___CWS
___ Court Ordered (DDC/CWS)
___Probation