**NURSE-FAMILY PARTNERSHIP REFERRAL FORM – SOUTHERN IN**

**NOTE: To qualify for the Nurse-Family Partnership (NFP) Program, a woman must:**

* **Be less than 28 weeks pregnant**
* **Have no previous live births**
* **Be low-income-eligible for Medicaid**
* **Live in Clark, Floyd, Washington, Scott, Orange, Jennings, Jackson, Jefferson, Lawrence, Harrison, and Crawford counties**

***Please verify by checking all that apply.***

An NFP nurse needs time to visit and obtain consent **before the 28th week** of pregnancy.

**Instructions:**

**Part 1**

* Complete of form
* Fax with cover sheet to **812-703-9553**
* **Call 812-283-7908**
* **NFPClarksville@goodwillindy,org**
* **Goodwill Portal:**

Date: / / Referring Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contact name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contact phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 1**

**Patient/Client Information**

|  |  |  |
| --- | --- | --- |
| Name: | Age: | Birthdate  |
| Confirmed with Pregnancy Test?□ Yes , Date / / □ No | Expected Delivery Date: / /  | Speaks English?□ Yes □ No | If No, Specify Language: | # of weeks Pregnant: |
| Address: | Apt: | Zip: |
| Additional Address: | Apt. | Zip: |
| Home Phone #: | Work Phone #: | Cell Phone #: | Email address: |
| Emergency Contact Person: | Relationship to Patient/Client: | Contact’s Home Phone #: | Work Phone #: | Cell Phone #: |
| Patient agrees to be referred to NFP & provide the information above regarding her pregnancy: □ Yes □ No | Patient’s/Client’s Signature: | Date: / /  |



Nurse-Family Partnership**®**
Implemented by
**Goodwill Industries of Central and Southern Indiana**
1329 Applegate Ln., Clarksville, IN 47129

**(812)- 283-7908**



**Part 1**

**To Be Completed by the Nurse-Family Partnership Site**

|  |  |
| --- | --- |
| Name: | Date: |
| Referral source (check one)1. □ WIC
2. □ Pregnancy Testing Clinic
3. □ Healthcare Provider/Clinic
4. □ School
5. □ NFP Client (current or past)
6. □ Other home visiting program
7. □ Medicaid
8. □ Goodwill Guide
9. □ Excel Center
10. □ Self \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. □ Other (includes human service agency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Goodwill affiliation: Employee Student Family member Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Disposition of Referral:□ 1. Enrolled in NFP Program Date of Enrollment: / /  |
| □ 2. Ineligible:  ***Reason:*** □ Not Pregnant □ >28 Weeks Pregnant □ Previous Live Birth □ Not in service area  □ Unable to locate □ Does Not Meet Income Guideline □ Other, Specify: ***Referred to:***  Healthy Families \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None - reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ 3. Refused to Participate □ Yes □ No  |
| Comments: |
|  |
|  |
|  |
| Completed by NFP Staff: | NFP Site: | Date: / /  |

Referral placed in DMCN

date:\_\_\_\_\_\_\_\_\_ initials\_\_\_\_\_\_\_\_

Referral assigned to Nurse

 date:\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_ nurse assigned\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral disposition updated

 date:\_\_\_\_\_\_ initials\_\_\_\_\_\_\_



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**Part 2**