**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**

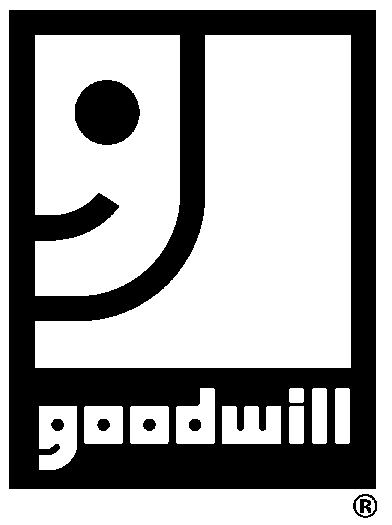
**Patient/Client Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

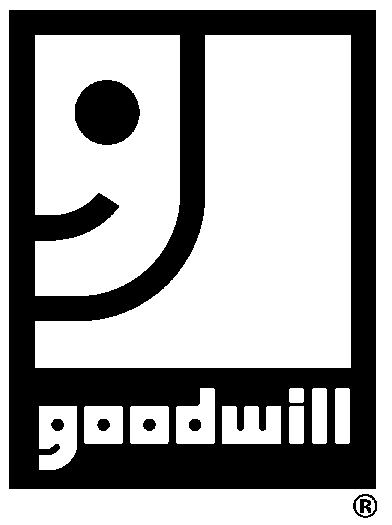
Referral disposition updated

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



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**Part 2**