REFERRAL FORM

Instructions

1. Complete this form
2. Securely fax with cover sheet to 317.659.8932
3. Call 317.524.4424 to verify fax was received

Nurse-Family Partnership® (NFP) referral criteria:

- Pregnant 28 weeks or less
- First time parent
- Meet income requirement (WIC or Medicaid eligible)
- Live in service area (NFP will verify)

REFERRING PARTY INFORMATION

Agency _____ Name _____

Phone _____ Email _____

County _____

PATIENT/CLIENT INFORMATION

Name		Birthdate
Expected Delivery Date	Preferred Language (if not English)	Phone Number ☐ Okay to text
Address		Zip

Optional: Please mark which of the following factors should also be considered for this patient/client (check all that apply):

☐ Age Group <18 or >35
☐ Developmental disability
☐ History of or current IPV
☐ Homeless
☐ Less than high school education or GED
☐ Medically complex
☐ Mental illness
☐ Previous low birth weight infant
☐ Previous or current involvement with CPS or foster care
☐ Previous pre-term birth
☐ Severe economic hardship
☐ Substance use
☐ Unemployment
☐ Other – Describe _____

Race: ☐ White ☐ Black ☐ Multi-racial ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Native Indian ☐ Alaskan Native ☐ Other

Patient/Client agrees to be referred to NFP and provide the information above: ☐ Yes ☐ No	Patient/Client's Signature (not required)	Date

Please submit through secure fax or secure email.

CONTACT US

117 N. Harrison Street | Shelbyville, IN 46176 | 317.524.4424 | goodwillindy.org/nfp