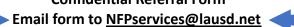


LOS ANGELES UNIFIED SCHOOL DISTRICT **NURSE-FAMILY PARTNERSHIP PROGRAM Confidential Referral Form**





REFERRALS ACCEPTED **ONLY** FOR THOSE WHO ARE <u>PREGNANT FOR THE FIRST TIME &</u> **LESS THAN 28 WEEKS PREGNANT**

| PERSON MAKING REFERRAL: | | Phone #: |
|---|---------------------------------------|--------------------------------|
| | Name & Title | |
| AGENCY/SCHOOL: | | Fax #: |
| CLIENT'S NAME: | | Birth date: |
| Address: | Unit/Apt.# | LMP: |
| | Unit/Apt.# | EDD. |
| Address: | Zip Code | Date of Expected Delivery |
| Phone #: | | Ethnicity: |
| Client's Primary language: | · | |
| Has Client been informed about th | nis referral? 🔲 Yes | □ No |
| Is the pregnancy confidential? | ☐ Yes | □ No |
| ISSUES OF CONCERN: (Known/Susp | pected – Please check all that apply) | |
| ☐ DEAF/HARD OF HEARING | ☐ SUSPECT DRUG/ALCOHOL USE | ☐ TOBACCO USE |
| ☐ BLIND/SIGHT IMPAIRED | ☐ MENTAL HEALTH CONDITION | ☐ FOSTER CHILD |
| ☐ PHYSICAL DISABILITY | ☐ FAMILY VIOLENCE | ☐ TRANSITIONAL AGE YOUTH (TAY) |
| ☐ JUVENILE JUSTICE INVOLVED | □ NO SUPPORT SYSTEM | ☐ HOMELESS |
| ☐ ADULT JUSTICE INVOLCED | ☐ DEPRESSION | ☐ UNSAFE LIVING CONDITIONS |
| ☐ EXPOSED TO TRAUMA | ☐ STRESSED FAMILY | ☐ OTHER: |
| COMMENTS: | | |
| **DO NOT WRITE BELOW THIS LINE – FOR PROGRAM USE ONLY** | | |
| Date Rec'd: | Clerk: | Sent to: |
| Confirmed Receipt: | | Disposition: |