LOS ANGELES UNIFIED SCHOOL DISTRICT
NURSE-FAMILY PARTNERSHIP PROGRAM
Confidential Referral Form
Email form to NFPservices@lausd.net

REFERRALS ACCEPTED ONLY FOR THOSE WHO ARE PREGNANT FOR THE FIRST TIME & LESS THAN 28 WEEKS PREGNANT

PERSON MAKING REFERRAL: _____ (Name & Title) Phone #: _____

AGENCY/SCHOOL: _____ Fax #: _____

CLIENT'S NAME: _____ Birth date: _____

Address: _____ (Street) _____ (Unit/Apt.#) LMP: _____

Address: _____ (City) _____ (Zip Code) EDD: _____ (Date of Expected Delivery)

Phone #: _____ Ethnicity: _____

Client's Primary language: _____

Has Client been informed about this referral? ☐ Yes ☐ No

Is the pregnancy confidential? ☐ Yes ☐ No

ISSUES OF CONCERN: (Known/Suspected – 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: _____