

Healthy Babies Referral Form

Date of Referral: _____

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Street Address: _____ Apt: _____ City: _____ Zip: _____

Phone: _____ Message Phone: _____ Email: _____

Attending School: YES NO If yes, which school: _____Race: American Indian/Alaska Native Asian Black/African American White/Caucasian Native Hawaiian/Pacific Islander More than One Race UnknownEthnicity: Hispanic/Latino Non-Hispanic/Not LatinoPrimary Language: English Spanish Other If Other please list: _____Secondary Language: English Spanish Other If Other please list: _____Interpreter Needed: YES NO Do you have health insurance? YES NOAre you pregnant? YES NO If yes, what is your due date? _____

If not pregnant, what is your baby's date of birth? _____

How many times have you been pregnant? _____ How many babies have you delivered? _____

Are you under 18 years of age? YES NO If yes, are your parents/guardians aware of this pregnancy? YES NOIf pregnant; have you been to a doctor for this pregnancy? YES NO

What clinic provides medical care for you (pregnant) or your child (delivered)? _____

How did you hear about our program? _____

Notes/Comments: _____

For Referral Source & Program Use OnlyReferred by: Self Parent/Guardian Agency Friend Other If other, please list: _____

Referring Party Name _____ Phone: _____

Fax: _____ Email: _____

Please email, fax, or mail referral to: Healthy Babies ~ Sedgwick County Health Department

1900 E. Ninth St. N. ~ Wichita, KS 67214 ~ Phone: (316) 660-7433 ~ Fax: (316) 660-0997 ~ Email: