EVERY CHILD SUCCEEDS REFERRAL FORM

Please complete the following and fax to **(513) 636-2460**
Questions? Call ECS at (513) 636-5486

1) Is this the mom's first baby? **yes** **or** **no**

2) Demographic Information for participating parent:

Mother's Name: _____ Mother's DOB: _____

Street Address: _____ Mother's SSN: _____

City, State: _____ Mother's email: _____

Zip code: _____

County: _____

Phone #: _____ Alternative #: _____

Emergency contact: _____ Emergency contact #:_____

3) Pregnancy and delivery information:

- Is the new mom: **Pregnant** or **Has Delivered**
- If **prenatal**: _____ weeks EDD _____
- Receiving prenatal care yet? Yes No OB/GYN _____
- If mom has **delivered**: Child's name: _____
- Child's DOB: _____ Is baby less than 12 weeks old? Yes No

4) Please <u>check</u> all that apply:

Mother is:

☐ Single/not legally married

☐ Low income (e.g. WIC, food stamps, Medicaid, etc) or no information on income

☐ Received late (after 12 weeks) or no prenatal care

☐ Young maternal age (under 18 years of age)

☐ Needs Interpretation Services Language: _____

Person making referral: _____ Date: _____
Name of Organization: _____ Phone #:_____
Fax #: _____

I consent to share the above information with Every Child Succeeds and request that ECS contact me to arrange an initial home visit. I understand that by signing this, I have no obligation to participate in the ECS program, and that even if I decide to participate I am voluntarily able to withdraw at any time.

_____ _____

Signature Date

02/14/17