EVERY CHILD SUCCEEDS REFERRAL FORM

Please complete the following and fax to **(513) 636-2460**
Questions? Call ECS at (513) 636-2830

1) Is this the mom's first baby? ☐ **Yes** ☐ **No**
Is this the dad's first baby? ☐ **Yes** ☐ **No**

2) Demographic Information for participating parent:

Parent's Name: _____ Parent's DOB: _____
Street Address: _____ Parent's SSN: _____
City, State: _____ Parent's email: _____
Zip code: _____ County: _____
Phone #: _____ Alternate #: _____
Best way to contact (check all that apply): ☐ Call ☐ Text
Emergency contact: _____ Emergency contact #: _____
Needs Interpretation Services? ☐ Yes ☐ No Language: _____
Check resources participating parent is receiving: ☐ Medicaid ☐ WIC

3) Pregnancy and delivery information:

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

4) Please check ALL that apply:

☐ Single/not legally married * ☐ Received late (after 12 weeks) or no prenatal care *
☐ Family Stressors ☐ Parent or family member uses tobacco
☐ Lack of support ☐ Concerns about depression
☐ Other: _____

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