WAYPOINT

Please email the completed form to HVreferrals@waypointnh.org or fax to 603-668-6260. For questions about making a referral, contact Carolyn George at 603-518-4390.

IDENTIFIED ADULT CLIENT FOR SERVICES:

Name:	DOB:
Home address: City, State, Zip code	
Primary phone: ☐Call ☐Text Email or alternate phone:	Interpreter needed: ☐Yes ☐No Language:

Others in the Home:

Name:	DOB:	Relationship to client:
Name:	DOB:	Relationship to client:
Name:	DOB:	Relationship to client:
Name:	DOB:	Relationship to client:
Name:	DOB:	Relationship to client:

If person being referred is pregnant, please complete the following fields:

Is this a first pregnancy? ☐ Yes ☐ No Due date:	Insurance: ☐ Medicaid ☐ Private ☐ None

Priority Consideration — Reasons for Referral:

☐ Smoker/vaping ☐ 1 or more children under 3 years ☐ Education below 10th grade ☐ Mental health concerns Diagnosis: ☐ Lack of prenatal care ☐ Substance use ☐Self ☐Partner ☐ Traumatic history (neglect, abuse) ☐ DCYF involvement last 12 months ☐ Domestic violence ☐Current ☐Past	☐ Developmental screening ☐ Unsafe or unhealthy conditions in the home ☐ Stress management ☐ Nutrition ☐ Safety concerns ☐ Support group/play group ☐ Budgeting/organizational skills	☐ Parenting (discipline, child development) ☐ Pregnancy & breastfeeding education ☐ Assistance with community resources ☐ Child care needs/concerns ☐ Other:

Further explanation:

Referring agency:_____ Date: _____

Contact person: _____ Phone: _____

I give consent for this referral and for Waypoint to communicate with the referring agency regarding this referral.

Signature of client:_____