WAYPOINT

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

- ☐ 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

Reasons for Referral:

- ☐ 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:

Please explain checked boxes:

Referring agency:_____ Date: _____

Contact person: _____ Phone: _____

I give consent for this referral. Signature of client:_____