



# WAYPOINT

Please email the completed form to [HVreferrals@waypointnh.org](mailto: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: <input type="checkbox"/> Call <input type="checkbox"/> Text	Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Email or alternate phone:	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Due date:	Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None
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### Priority Consideration                      Reasons for Referral:

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

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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: \_\_\_\_\_