HASTINGS PRINCE EDWARD
Public Health

Healthy Families Referral
Fax to: 613-966-4363

Date: _____

Referrer information (if applicable)
Please enter the contact name and name of the agency/health care provider submitting the referral.

Contact name _____

Agency _____

Client Information

Client name * _____ **Client date of birth** * _____
yyyy – mm - dd

Address * _____

City * _____ **Postal Code** _____

Phone * _____

Referral type *

○ **Prenatal** **EDD:** _____ **Previous parenting experience: Yes** ☐ **No** ☐
yyyy - mm – dd

**** Reason for Referral***

☐ **Prenatal Education & Support** ☐ **Breastfeeding** ☐ **Perinatal or Postpartum Depression/Anxiety**

○ **Postpartum (0-6 weeks)**

If Known: Gestational Age: _____ **wks.** **Baby's DOB:** _____
yyyy - mm - dd

**** Reason for Referral***

☐ **Breastfeeding** ☐ **Infant Feeding** ☐ **Positive Parenting** ☐ **HBHC**

☐ **Growth and Development** ☐ **Perinatal or Postpartum Depression/Anxiety**

○ **Early Childhood (6 weeks to 6 years)**

**** Reason for Referral***

☐ **Breastfeeding** ☐ **Infant Feeding** ☐ **Positive Parenting** ☐ **HBHC**

☐ **Growth and Development** ☐ **Perinatal or Postpartum Depression/Anxiety**

Client consent *

The client has given permission for this form to be sent to the Hastings Prince Edward Counties Health Unit so that a public health nurse can contact them regarding the Healthy Families programs and, if necessary, communicate with your health care provider. They understand the Health Unit will keep their information confidential and will use it for the purpose of administering the programs.

☐ **Client Consent Obtained**