Rhode Island
Maternal and Child Family Home Visiting System

Referral Form

If you feel a pregnant woman or family would benefit from support or services in their home, please fax this form to the First Connections agency in their community, an Early Intervention program, or to RIDOH at 401-222-5688. See the back of this form for a list of agencies.

1. Referral Source Information

Name of Referrer _____ Date _____

Agency / Provider _____ Position Title _____

Phone _____ Fax _____

Email _____

2. Parent / Guardian Information

First Name _____ Last Name _____

Birth Date _____ Relationship to Child _____

First Time Mother ☐ Yes ☐ No Due Date _____

Language - Primary _____ Preferred _____

Street Address _____ City, RI ZIP Code _____

Mailing Address (if different) _____ City, RI ZIP Code _____

Home Phone _____ Cell Phone _____

Email _____

Preferred Contact Methods ☐ Cell Phone ☐ Home Phone ☐ Text ☐ Email

Insurance Type ☐ Public ☐ Private ☐ None

3. Child Information

First Name _____ Last Name _____

Birth Date _____

Street Address _____ City, RI ZIP Code _____

4. Parent/Guardian of Minor Pregnant Woman Information

First Name _____ Last Name _____

Language - Primary _____ Primary Phone _____

Street Address _____ City, RI ZIP Code _____

Relationship to Pregnant Woman _____

5. Reason for Referral

☐ Basic Needs ☐ Breastfeeding Support ☐ Child Development Questions

☐ Community Resources ☐ Comprehensive Evaluation (EI only) ☐ Developmental Screening

☐ Social and Emotional Support ☐ New Parent ☐ Parent Education/Support

☐ Other: _____

Developmental Screening Results Sent with Referral? ☐ Yes ☐ No Additional Attachments Included? ☐ Yes ☐ No

6. Consent to Refer and Release of Information

I, _____ (Name of parent/guardian) give my permission for _____ (name of program referred to) to share the results of this referral with _____ (name of referral source). Information shared will include verification that my referral is in process, whether my child or I are eligible, and enrollment status. This information is needed to help coordinate services for which my family may be eligible.

Signature: _____ Date:

Preferred Program: _____