The Children's Home Society OF NEW JERSEY®

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www.chsofnj.org

PERINATAL COMMUNITY INTEGRATION MODEL
REFERRAL FORM

Fax to: 609-394-5769

Email to: sgarcia@chsofnj.org

***** PLEASE COMPLETE ALL SECTIONS – ENTER N/A IF NOT APPLICABLE *****

Patient's Name (print): ____ Date of Birth: ____________________

Address: ______________________________ City ____________________ State ________ Zip ________________

Home Phone: _______________ Mobile Phone: __________________ Spouse/Family Member ____________________

Spoken Language: ☐ English ☐ Spanish ☐ Creole ☐ Russian ☐ Polish ☐ Other: ___________

EDD: _____/_____/________ N/A ☐ Infant date of birth: _____/_____/_________

Do you agree to receive communication via text from the agency? Yes ☐ No ☐

Client/Patient Consent

I agree to provide the above information and to have it forwarded as a referral to available service agencies in my community. I agree to be contacted and for Perinatal Community Integration Model to follow up with me about the services I'm requesting and the agency to which I am being referred to support my care. Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

Signature: ____ **Date:** ______________________________

Reason for referral:

☐ Prenatal Care ☐ Postpartum Support ☐ Substancie Abuse ☐ Food Insequirity

☐ Health Advocacy ☐ High Risk Pregnancy ☐ Social Services ☐ Housing

☐ Counseling ☐ Public Services Application (WIC, SSI, SNAP, etc.) ☐ Other ____________________________________

REFERRED BY:

Full Name ______________________________________ Organization ______________________________

Title ____ E-mail address _____________________________

Address ____ City ______________________ State __________

Phone Number ___________________________________ Fax Number _______________________________

Staff Signature __________________________________ Date _____________________________________

For use ONLY by the Perinatal Community Integration Model (PCIM) staff:

DATE ENTERED INTO EVOLV _____/______/______ INITIALS____________ INTAKE APPOINTMENT ____/____/_____ @ ______ AM/PM

NOTES:

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CONFIDENTIAL COMMUNICATION

THIS FAX, INCLUDING ANY ATTACHMENTS, MAY BE INTENDED SOLELY FOR THE PERSONAL AND CONFIDENTIAL USE OF THE SENDER AND RECIPIENTS(S) NAMED ABOVE. THIS FAX MAY INCLUDE ADVISORY, CONSULTATIVE AND/OR DELIVERATIVE MATERIAL AND, AS SUCH, WOULD BE PRIVILEGED AND CONFIDENTIAL AND NOT A PUBLIC DOCUMENT. ANY INFORMATION IN THIS FAX IDENTIFYING A CLIENT OF THE CHILDREN'S HOME SOCIETY OF NEW JERSEY IS CONFIDENTIAL. IF YOU HAVE RECEIVED THIS FAX IN ERROR, YOU MUST NOT REVIEW, TRANSMIT, COPY, USE OR DISSEMINATE THIS FAX OR ANY ATTACHMENTS TO IT AND YOU MUST DESTROY THIS FAX. YOU ARE REQUESTED TO NOTIFY THE SENDER BY RETURN FAX IF YOU HAVE RECEIVED A FAX IN ERROR. ALSO, CONFIRM YOUR DESTRUCTION OF THE ERRONEOUS FAX AND RELATED ATTACHMENTS.