NURSE-FAMILY PARTNERSHIP REFERRAL FORM
ROBESON COUNTY/COLUMBUS COUNTY

NOTE: To qualify for the Nurse-Family Partnership (NFP) Program, a woman must:

- **Be less than 28 weeks pregnant (preferably by 16 wks or <)**
- **Have no previous live births(cannot have been issued a birth certificate)**
- **Be low-income**
- **Live in targeted area/county (Robeson Co.)**

An NFP nurse needs time to visit and obtain consent before the 28th week of pregnancy.

*****REFERRAL SOURCE: PLEASE COMPLETE ALL FIELDS-ALL FIELDS ARE REQUIRED BY OUR NSO*****
Instructions: Complete Part 1 and Part 2 of form. Fax to (910) 608-2120 Robeson Co. or Columbus Co. (910) 640-1088
Please notify site if sending the referral via fax (HIPAA requirement)

Referral Date: _____

Part 1 Client Information: Medicaid: □Yes □No/Private Ins: □Yes □No/Family Income:

Name:		**Age:**	**Birthdate**	**# of weeks Pregnant:**
Confirmed with Pregnancy Test? □ Yes , Date / / □ No	**LMP:** / /	**Expected Delivery Date:**	**Speaks English?** □ Yes □ No	**If No, Specify Language:**
Physical Address:	**Apt:**	**May contact by phone** □Y□N **Best time to call:** _____	**Race** (Circle all that apply): American Indian or Alaska Native; Asian; Black or African American; native Hawaiian or Pacific Islander; White; Declined to self-identify **********	**Ethnicity (Circle one):** Hispanic or Latina; Not Hispanic or Latina; Declined to self-identify **********
City:	**State/Zip:**	**Risk Factors:**		
Home Phone #:	**Work Phone #:**	**Cell Phone**		

Emergency Contact Person: Relationship to Patient/Client: Contact's Home Phone #: Work Phone #: Cell Phone #:

□By checking this box you give permission for NFP to speak with the emergency contact listed above concerning you or our program

Client agrees to be referred to NFP & provide the information above regarding her pregnancy: □ Yes □ No	**Client's Signature:**	**Date:** / /

Part 2 Referring Agency/Practice Information

Agency/Practice Name, Facility or Division & Address	**Date:** / /
Referring Staff Name:	**Title:**

Part 3 To Be Completed by the Nurse-Family Partnership Site

Referral Source: □ 1. WIC □ 2. Pregnancy Testing Clinic □ 3. Healthcare Provider/Clinic □ 4. School □ 5. NFP Client (current/past) □ 6. Other home visitation program □ 7. Medicaid □ 8. Self □ 9. Other (includes other human service agency)

Disposition of Referral: □ 1. Enrolled in NFP □ 2. Refused participation □ 3. Unable to locate □ 4. Did not meet NFP criteria □ 5. Did not meet local criteria □ 6. Program full □ 7. Already enrolled in another program □ 8. Unable to serve due to language

If ineligible: □ >28 Weeks Pregnant □ Previous Live Birth □ Unable to Locate □ Other: (Specify)

Contact Log:

Robeson County Health Department
460 Country Club Road
Lumberton, NC 28358
(910) 671-3225; (910) 671-3224; Fax (910) 608-2120

Columbus County Health Department
304 Jefferson Street
Whiteville, NC 28472
(910) 640-6615 FAX (910) 640-1088

☐ Keyed in ETO referrals ☐ Dismissed from referrals ☐ Dismissed from ETO/NFP ☐ Enrolled in NFP