

Healthy Babies Healthy Children REFERRAL FORM

Name:			
Date of Birth:			
Address:			Place mother's addressograph here
Postal Code:			
Health Card #:			
*Due Date (prenatal clients	only):		*Current Phone:
Email:			Cell Phone:
*Mandatory Fields			Text Message: ☐ Yes ☐ No
Worker Safety Concerns?	□ Yes	If yes, attend	with co-worker □ OR contact CAS □
	□ No		
Safety Concerns include:			
Children's	Names		Date of Birth
1.			
2.			
		Reason for	r Referral
Baby/Child's Health (age of	child, conc	erns)	
Parent(s) Health			
Parent(s) Emotional/Mental	Health		

Stressors (Finances, housing, parenting, relationship)			
Supports (Does family have help?)			
Other services involved			
Additional Comments			
Client Consents to HBHC Services: ☐ Yes ☐ No			
Accessibility Barriers:	reter S	ervices:	□ Yes
□ No			□No
Name of Referring Agency:			
Agency Contact: Phone	Numb	oer:	
Does referring agency plan to continue services with family	y? [∃Yes	□ No
Signature:		Date:	

Wawa	Sault Ste. Marie	Blind River	Elliot Lake	
705-856-7208 1-888-211-8074	705-942-4646 1-888-537-5741	705-356-2551 1-888-356-2551	705-848-2314 1-877-748-2314	
Fax: 705-856-1752	Fax: 705-541-7308	Fax: 705-356-2494	Fax: 705-848-1911	