



**PRENATAL / POSTNATAL REFERRAL FORM**  
**CHILDREN'S RESOURCE COUNCIL – FAMILY RESOURCE NETWORK**  
**FAX TO: 780-523-4117 or EMAIL TO: hpdrcr@telus.net**

Referring Agency/Hospital: \_\_\_\_\_ Date: \_\_\_\_\_

Screen/Referral Completed by: \_\_\_\_\_ Request call back: \_\_\_\_\_

Partner/Mother's Name: \_\_\_\_\_

Partner/Father's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Information	Infant A	Infant B
Infants Name / Preferred Pronoun		
Sex	M / F	M / F
Weights (lbs/oz)		
Date of Birth		
Current Diagnosis / Health Concerns		

Conditions of Risk	
1	Marital Status – single, parenting alone
2	Income – inadequate income, partner unemployed
3	Housing – unstable
4	Communication – no phone
5	Education – less than high school completion
6	Substance abuse – history / current
7	Maternal Health – late prenatal care, NPC or contact with physician, considered ending pregnancy.
8	Maternal Knowledge – concern regarding mother's / parent's ability to understand and use skills needed to care for baby.
9	Mental Health – history of psychiatric care, mental health issues, depression, addiction issues.
10	Age – under 20 years
11	Health – concerns for mother / infant, nutrition or breastfeeding issues, presence of child disability or delay.
12	Family Crisis - relationship issues, family violence
13	Isolation – social / geographically isolated, new to community, no transportation
14	Recent immigrant, refugee or language minority, Indigenous (FNMI)
15	Child maltreatment - history / current child abuse or neglect, Children's Service involvement

\_\_\_\_\_ (Initial) CONSENT given to share contact with High Prairie & District Children's Resource Council to receive free Baby Welcome Bag.

\_\_\_\_\_ (Initial) CONSENT given to be contacted by the High Prairie & District Children's Resource Council to receive support services.



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FOR OFFICE USE ONLY:

**Positive For Early Intervention / Intervention if:**

- 1 – Yes to 1, 7, 8, 10, 11, 12, 15
- 2 – 3 or more factors present. (Also, eligible for nutritional supports.)
- 3 - 5+ unknowns

**ALL Positive Screens proceed to voluntary early intervention and parent survey assessment.**

- Client **AGREES** to be involved in Early Intervention / Health Services provided by HPDCRC.
- Client **DECLINED** to be involved in Early Intervention / Health Services provided by HPDCRC.

Navigation:

- Referred to other program / spoke: \_\_\_\_\_
- CRC Placement:

	FRN HUB	CAPC	CPNP	ST	BFNS	CHARITY
Primary Supports Service Domain	<input type="checkbox"/> Child Development and Well-being <input type="checkbox"/> Caregiver Capacity Building <input type="checkbox"/> Social Connections & Supports	<input type="checkbox"/> Child Development and Well-being <input type="checkbox"/> Caregiver Capacity Building <input type="checkbox"/> Social Connections & Supports	<input type="checkbox"/> Child Development and Well-being <input type="checkbox"/> Caregiver Capacity Building <input type="checkbox"/> Social Connections & Supports	<input type="checkbox"/> Child Development and Well-being <input type="checkbox"/> Caregiver Capacity Building <input type="checkbox"/> Social Connections & Supports <input style="color: red;" type="checkbox"/> Social Connections & Supports	<input type="checkbox"/> Child Development and Well-being <input type="checkbox"/> Caregiver Capacity Building <input type="checkbox"/> Social Connections & Supports	<input type="checkbox"/> _____ <input type="checkbox"/> _____
Continuum of Service Recommended	<input type="checkbox"/> Universal/Preventative <input type="checkbox"/> Targeted/Early Intervention <input type="checkbox"/> Intensive/Intervention	<input type="checkbox"/> Universal/Preventative <input type="checkbox"/> Targeted/Early Intervention <input type="checkbox"/> Intensive/Intervention	<input type="checkbox"/> Universal/Preventative <input type="checkbox"/> Targeted/Early Intervention <input type="checkbox"/> Intensive/Intervention	<input style="color: red;" type="checkbox"/> Universal/Preventative <input type="checkbox"/> Targeted/Early Intervention <input type="checkbox"/> Intensive/Intervention	<input type="checkbox"/> Universal/Preventative <input type="checkbox"/> Targeted/Early Intervention <input style="color: red;" type="checkbox"/> Intensive/Intervention	<input type="checkbox"/> Preventative <input type="checkbox"/> Early Intervention <input type="checkbox"/> Intensive/Intervention
Service Area	<input type="checkbox"/> SR <input type="checkbox"/> BLC <input type="checkbox"/> LSR <input type="checkbox"/> O <input type="checkbox"/> EP, P, GL <input type="checkbox"/> Other: _____	<input type="checkbox"/> BLC <input type="checkbox"/> EP, P, GL <input type="checkbox"/> Other: _____	<input type="checkbox"/> BLC <input type="checkbox"/> EP, P <input type="checkbox"/> Other: _____	<input type="checkbox"/> SR <input type="checkbox"/> BLC <input type="checkbox"/> LSR <input type="checkbox"/> O <input type="checkbox"/> Other: _____	<input type="checkbox"/> SR <input type="checkbox"/> BLC <input type="checkbox"/> LSR <input type="checkbox"/> O <input type="checkbox"/> Other: _____	<input type="checkbox"/> SR <input type="checkbox"/> BLC <input type="checkbox"/> LSR <input type="checkbox"/> O <input type="checkbox"/> EP, P, GL <input type="checkbox"/> Other: _____

Referral Received by / Date: \_\_\_\_\_

Screen Reviewed by: \_\_\_\_\_

Contact made by / Date: \_\_\_\_\_

Gift Delivery by / Date: \_\_\_\_\_

Service Intake by / Date: \_\_\_\_\_