easterseals
Southeast Wisconsin

REFERRAL TO: Safe Babies Healthy Families
FAX: (414) 571-5568; PHONE: (414) 731-7978
lindseyw@eastersealswise.com

Type of Referral: ☐ Pregnancy ☐ Infant

Referring Agency/Provider: _____
Name of Person Referring: _____
Phone: _____
Fax: _____

REASON FOR REFERRAL - Mother and/or Family Risks (Check all that apply)

- ☐ Bonding Problems
- ☐ Complications of pregnancy/delivery
- ☐ Depression
- ☐ Dysfunctional factors in family
- ☐ History of family violence
- ☐ Lack of information on parenting/anxiety about parenting
- ☐ Lack of support system
- ☐ Language Barrier
- ☐ Last birth <12 months ago
- ☐ Limited cognitive/learning ability
- ☐ Mother's education <12th grade
- ☐ Mother's age <18 or >40
- ☐ Multiple birth
- ☐ Parental substance use/abuse
- ☐ Prenatal care late or <4 visits
- ☐ Previous infant loss
- ☐ Recent immigrant
- ☐ Severe financial problems
- ☐ Single mother
- ☐ Special diet/meds
- ☐ Unstable housing

Other risks/comments/information: _____

MOTHER'S INFORMATION

Mother's Name: _____
Address: _____
City/Zip: _____

G _____ P_____ EDC _____ Delivered _____

DOB Phone _____

Race (choose one)

Ethnicity (choose one)

Additional Contact Information
Name: _____
Phone _____
Relationship to Client: _____

INFANT'S INFORMATION

Infant's Name: _____

DOB Gender (choose one)

Race (choose one)

Ethnicity (choose one)

Birth Weight ____lbs ____oz Length _____in.

Discharge Wt ____lbs ____oz Gestation _____wks

☐ Breastfeeding_____ ☐ Bottle _____

Infant Medical Risks (check all that apply)

- ☐ Congenital anomalies/genetic disorder
  Briefly explain.
- ☐ Physiological or functional deviation
  Briefly explain.
- ☐ Small/large for gestational age
- ☐ Elevated bilirubin
- ☐ On apnea monitor/other equipment
  Briefly explain.
- ☐ Positive drug screen
  List drugs found
- ☐ Other