Del Norte County Healthy Families Referral Form

Enrollment Criteria

☐ Pregnant or newborn under 3 months of age OR
☐ CWS- Up to 24 months to enroll AND
☐ Resident of Del Norte County and Tribal Lands

Caregiver Last Name:_____ Phone number_____
Caregiver First Name:_____ Email _____
Current Address:_____ City/State/Zip_____
Language: _____ Interpreter Needed? ☐ Yes ☐ No
Ethnicity: ☐ Hispanic ☐ Non-Hispanic Race: _____
Preferred Contact Method (required)
☐ Email ☐ Phone call ☐ Text
Pregnant ? ☐ Yes ☐ No First Pregnancy? ☐ Yes ☐ No
If yes, what is the expected date of delivery? _____
If no, skip to the next question.
Child's Date of Birth: Month_____Date_____Year_____
Are there any other children or adults in the home and if so, what are their ages? Any special needs?

Educational Level

☐ High School ☐ College ☐ Other

Medical Information

Provider_____ Phone Number _____
Health Insurance_____
Has the newborn been diagnosed with any acute or chronic medical conditions that we should be aware of or any issues experienced at birth? If so, please explain. _____
Results of newborn hearing screening, if performed?_____
What concerns does the caregiver have? (Check all that apply)

☐ Parenting skills/education ☐ Information on finding resources ☐ Developmental Milestones
☐ Food insecurity ☐ Medical support ☐ Stress/self-care/mental health
☐ Meeting other parents ☐ Breastfeeding support ☐ Oral health
☐ Building a support system ☐ Understanding behaviors ☐ Child safety
☐ Parent-child activities ☐ Establishing routines ☐ Other

Additional comments:_____
What is the number one thing you want us to know about your family?

Referral Information

Referring agency:_____ Staff Name::_____
Date of Referral: _____ Phone number_____
Parent Signature:_____ Date:_____
Return referrals to _____ Fax: 707-465-6701 Confidential Email: _____