

Initial Referral Form - Mercer County

*** REQUIRED ***

*** Date of Referral**

Participant Information

____ - ____ - ____

* Last Name

* First Name

* Date of Birth

____ - ____ - ____

* Street Address

* City

* Zip Code

* County

Participant ID

* Primary Language

* Race

* Ethnicity

Hispanic Yes No

* Health Insurance (Select all that apply)

(Choose one)

(Choose one)

English

Black

Multi-Racial

Medicaid PE

Medicare

Spanish

White

Alaskan/Pacific Islander

Medicaid MC

Commercial/Private

Other _____

Asian

Other _____

NJ Family Care

Uninsured/Self Pay

Native American

Participant Contact Information

* Preferred Contact Method

Household Information

Married?

* # of Children in the home

____ - ____ - ____

(Choose one)

Primary Phone Email

Date(s) of birth of children needing services

Yes No

* Primary Phone

Alternate Phone Text

Name of Child

Relationship

____ - ____ - ____

* At which phone number can we text you?

Primary None

Alternate

1. ____ / ____ / ____

2. ____ / ____ / ____

3. ____ / ____ / ____

Email Address

Participant Is... (Choose One)

Preconceptional Woman

Pregnant Woman

Interconceptional Woman

Male

Has no children and has never been pregnant.

* First Time Parent?

Yes No

* In Prenatal Care?

Yes No

* Due Date

____ - ____ - ____

Previously pregnant and not currently pregnant.
(Does not matter if woman has children.)

* First Time Parent?

Yes No

* Are you a Parent?

Yes No

* First Time Parent?

Yes No

Does your child live w/ you?

Yes No

Reason for Referral - Household Needs

___ Primary care for myself

___ Public benefits

___ Group parent support

___ Primary care for my children

___ In-home parent support (home visiting)

___ Recovery Support Services

___ Prenatal care

___ Assistance connecting to services (CHW)

___ Other _____

Referral Agency Information

* Referral Agency Name

Name of Person Making the Referral

Phone

Email Address

Phone Extension

Comments

Program Use Only

Date Pregnancy Test Given

____ - ____ - ____

Pregnancy Test Positive?

Yes No

Outreach Type

Agency Door to Door

Self

Event (Specify) _____

* Participant Consent

I agree to have the information I provided for this initial referral shared with the Central Intake hub for my county. I agree to be contacted by Central Intake staff, who will further assist with connecting me and/or my family to supportive services.

Oral consent given

Signature of Participant

Sign _____ Print _____

Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

Fax form to: 732-937-5540 or Email infoci@cjfhc.org