Healthy Montana Families Inter-Agency Referral Form

Date of Referral: _____

Agency/Organization Name:	
Staff Name:	
Contact Number:	

A. General Information

(*indicates required field)

Child(ren):			**Target Caregiver:**	
*Name:	*DOB:	Age:	*Name:	*DOB:
			Pregnant? **Y**☐ / **N**☐	Estimated Due Date:
			Relationship to child(ren):	
			*Phone Number:	
			Street Address:	City:

***Reason for Referral:**

☐Alleged Domestic Violence	**Secondary Target Caregiver:**
☐Alleged Substance or Alcohol abuse	Relationship to child(ren):
☐Alleged Child abuse or neglect	Phone Number:
☐Prenatal/Postpartum support	Street Address: City:
☐Other:	
	Child in Foster care or Kinship care? **Y** ☐/ **N**☐

Consent to Refer for Services Parent/Caregiver Signature: _____ Date: _____

B. Asthma

Do any of the children have asthma? If Yes, please fill out this box. If No, please move on to Section "C."

Child(ren)'s Provider:	
Last ED Visit/Hospitalization/Urgent Care visit due to asthma (if known):	
Asthma Control Test (ACT) score (if known):	Date of ACT:
Concerns about the Child(ren)'s asthma:	

C. Community Resources

Is the family currently working with anyone from: ☐Head Start ☐Nurturing Center ☐CPS

D. Assistance With Resource Needs in the Following Areas (Check all that apply):

- **Nutrition Information**: ☐WIC ☐Breastfeeding Support ☐Food Assistance
- **Support**: ☐Mental Health ☐Postpartum Depression ☐Financial ☐Communication Skills ☐Teen Parenting ☐Substance Abuse ☐Domestic Violence Education ☐Goal Setting ☐Kindergarten Readiness ☐Smoking Cessation ☐Housing Assistance ☐Sibling Relationships
- **Parenting**: ☐Education ☐Newborn/Child safety ☐Child Care ☐Child Development
- **Medical**: ☐Immunization information ☐Medical Coverage ☐Medical/Dental Care ☐Referrals for Child's Hearing, Speech, Vision, Development ☐Birth Control
  - **Other**_____

_____

Please return this form to:

Flathead City-County Health Department
Phone: 758-2180 Fax: 1-866-380-1740

Parents as Teachers™

Great Referrals:

- Ages 0 thru 3
- Family displays difficulty or desires additional support in meeting the health/safety/developmental needs of the child
- Parent may benefit from further community connections/resource referral

Program Highlights:

- Increase parent knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Improve school readiness and school success.
- Supports and encourages parent involvement and parent child-interaction
- Long term home connections (2-3 years possible)

Montana Asthma Program

Great Referrals:

- Reside in Flathead County
- Age 17 or younger
- Have had at least 1 ER, Urgent Care visit, or hospitalization in the last 12 months
    - OR An Asthma Control Test score of less than 20

Program Highlights:

- 6 Home Visit contacts over the course of a year with an RN
- Detailed information on asthma medications and how to properly use them
- Home Assessment for environmental triggers and allergens and ways to reduce them
- Asthma friendly mattress and pillow covers for the child's bed/pillow
- HEPA-grade air filter if needed