Healthy Montana Families Inter-Agency Referral Form

Date of Referral: _____

Agency/Organization Name:	
Staff Name:	
Contact Number:	

Child(ren):		
Name	DOB	Age

Target Caregiver:	
Name	DOB
Pregnant? ☐ Y ☐ N	Estimated Due Date:
Relationship to child(ren):	
Phone Number	
Street Address	City
Secondary Target Caregiver:	
Name	DOB
Relationship to child(ren):	
Phone Number	
Street Address	City
Child in Foster care or Kinship care? ☐ Y ☐ N	
Reason for Referral:	
☐ Alleged Domestic Violence	
☐ Alleged Substance or Alcohol Abuse	
☐ Alleged Child Abuse or Neglect	
☐ Prenatal/Postpartum Support	
☐ Other	
Consent to Refer for Services:	
Parent/Caregiver Signature: _____	Date: _____

Community Resources:	
Is the family currently working with anyone from: ☐ Head Start ☐ Nurturing Center ☐ CPS	
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 ☐ Referral for child's hearing, speech, vision, development ☐ Birth control ☐ Other _____

Please return this form to the Flathead City-County Health Department. Phone 406-758-2180 Fax 1-866-380-1740