Virginia's Home Visiting Consortium Universal Referral Form

Please PRINT to complete this form for referring a child/family for home visiting services.
Also please indicate the feedback that you want to receive from the receiving home visiting program in response to your referral.

Section 1. Home Visiting Program Referral (☑)

REFERRAL TO: (check one)

- ☐ Medicaid High Risk Infant/Maternal Program
- ☐ Healthy Families
- ☐ Loving Steps
- ☐ Appropriate Home Visiting Program
- ☐ CHIP
- ☐ Resource Mothers
- ☐ Project Link
- ☐ Other:
- ☐ Part C Early Intervention
- ☐ Early Childhood SPED
- ☐ Early Head Start/Head Start

Section 2. Who Is Making This Referral?

Person Making Referral:____________________________ Date of Referral:_____/_____/_____

Agency/Program____________________________________

Address:____________________________________

Office Phone_____/_____-____________ Office Fax:_____/_____-____________

E-mail ____________________________________

Signature:____________________________________

Section 3. Who is Being Referred? (Complete as applicable)

☐ Child ☐ Pregnant Woman/Teen ☐ Mother ☐ Father ☐ Family

Name of Infant/Child being referred____________________ Date of Birth: ____/____/____ Gender M F

Home Address: ____________________ City____________ VA Zip_______

Primary Parent/Caregiver____________________ Relationship to Child: ____________

Primary Language:__________ Home Phone:____________ Other Phone:____________

Name of Pregnant Woman/Teen being referred________________ Date of Birth: ____/____/____ EDD _______

Home Address:____________________ City____________ VA Zip_______

Primary Language:__________ Home Phone:____________ Other Phone:____________

Name of Parent/Caregiver being referred: ____________ Date of Birth: ____/____/____ Gender M F

Home Address:____________________ City____________ VA Zip_______

Primary Language:__________ Home Phone:____________ Other Phone:____________

Best time to call or visit: ______________________________

Section 4. Reason(s) for Referral and Referral Information (☑)

- ☐ Pregnant
- ☐ New Parent
- ☐ Child development services
- ☐ Perinatal Depression/other mental health concerns
- ☐ Parent Education/Support
- ☐ Premature Birth
- ☐ Teen Pregnancy
- ☐ Parent Support
- ☐ Maternal alcohol/substance use
- ☐ Other reason for referral or more information related to checked areas:
- ☐ Diagnosed medical condition
- ☐ Custodial Grandparent
- ☐ Well child health

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Section 5. Status/Feedback Requested by the Referral Source (☑)

- ☐ Status of Initial Family Contact
- ☐ Services Being Provided to Child/Family
- ☐ Developmental Evaluation Results
- ☐ Child Progress Report/Summary
- ☐ Other:____________________________

☐ **Eligibility offered? If so, outcome:** ☐ **Enrollment Accepted** ☐ **Enrollment Declined**

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Extent or nature of use/disclosure is limited to: (☑ or list all that apply)

- ☐ Screening
- ☐ Evaluation/Assessment
- ☐ Treatment/service plan (IFSP/IEP)
- ☐ Progress Notes
- ☐ Participation in Treatment
- ☐ Psychological Evaluation
- ☐ Health/physical information & history
- ☐ Infectious Diseases
- ☐ Prenatal care
- ☐ Substance use & treatment history
- ☐ Mental health information & treatment history
- ☐ Medications prescribed
- ☐ Finances & employment
- ☐ Family & interpersonal functioning
- ☐ Services Received
- ☐ Other referrals being made
- ☐ Discharge Summary
- ☐ Other: ______________________________ ☐ Other: ______________________________

Specified purpose or need for use/disclosure is: Referral for Services and Coordination of Care

In order to make a referral and/or coordinate care for myself and/or ______________________________(Child's Name),

I give permission to: ______________________________(Referral Source)

to disclose the protected health information noted above to:

______________________________,
(Home Visiting Program Name, Street Address, City, State, Zip Phone/Fax #)

I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information.

Permission is hereby given to: ______________________________
(Local Home Visiting Program)

to disclose information to: ______________________________,
(Referral Source Name, Title)

____
(Organization/Program Name)

____
Street Address/Mailing Address

____
(City, State, ZIP)

Telephone: (   ) ______________________ Fax: (   ) ______________________

I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that:

This authorization ___does ___ does not extend to information placed in my record after the date I signed this form.

I acknowledge that I have read and understand the following.

- My treatment will not be affected by my willingness or my refusal to sign this form
- The referral source cannot condition the provision of treatment to me on my signing of this authorization.
- This authorization form or a copy of it will be included with my original records.
- I have the right to revoke this authorization at any time. I am aware that, if I do revoke my authorization, this will not affect any information which has already been released in accordance with this authorization.
- Federal Regulation (42 CFR Part 2) specifically prohibit individuals or agencies from re-disclosing any information regarding alcohol or substance abuse treatment without my specific authorization
- I am aware that any other information disclosed as a result of this authorization may be re-disclosure by the recipient and is, therefore, no longer protected by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule or the Family Education Rights and Privacy Act (FERPA).

Signature of Individual (adult) or Legally Authorized Representative______________________________

Relationship______________________ **Date Signed**______________________

If not previously revoked, this authorization will expire in: ___90 Days ___One Year ___On *(specify date or event)*______________________
The information may be disclosed effective: ____Immediately ___*(specify date)*______________________