Referrals to NFP Program

Fax to 828-520-7126

Referral Information:

First Name _____ Last Name _____

Date of Birth _____ Due Date _____

Preferred Language _____ Race _____

Ethnicity ☐ Hispanic or Latina ☐ not Hispanic or Latina

Eligible for WIC or Medicaid? ☐ Yes ☐ No Permission to give information to NFP? ☐ Yes ☐ No

911 Address _____

_____

City _____ State _____

Zip Code _____ Email _____

Cell Phone _____ Home phone _____

Work Phone _____ ☐ Declined to provide cell phone #

Emergency Contact _____ Phone _____

Emergency contact aware of pregnancy? □ Yes □ No

Referral Source:

Date of Referral _____ Primary Source Name _____

Location _____ Phone # _____

Follow-up Nurse Home Visitor _____

Contact Log _____

Nurse Family-Partnership

Eastern Band of Cherokee Indians

P.O. Box 666

Cherokee, NC 28719

828-359-6250

Last Name_____ First Name_____ MI_____

D.O.B._____ Race_____ Ethnicity_____

Physical Address_____

_____

Phone #_____

Emergency Contact_____ Phone #_____

EDD_____ Medical Provider_____

G___T___P___A___L___ Initial B/P_____ Pregravid wt. _____ Ht._____

RISK FACTORS (ex. HTN, diabetes, psychiatric illness)_____

_____

_____

*Referral Source Signature*_____ *Physician Signature*_____

For NHV only (to ask client) Medicaid #_____

1. How did you first hear about NFP?
2. What have you heard about NFP?