

For Office Use Only
Date:
Case No:
Case assignment:

**CONFIDENTIAL  
REFERRAL / INTAKE FORM**

Date:	
Referring Agency:	
Agency Point Person:	
Primary Staff Person: (Who works w/ family)	
Primary Staff Phone:	
Primary Staff Email:	
Family Informed of referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parents Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership
Language(s) of family:	

Name of Child:	
Date of Birth:	
Age:	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Ethnic Origin:	<input type="checkbox"/> White <input type="checkbox"/> Latino <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific <input type="checkbox"/> Amer. Indian/Alaskan <input type="checkbox"/> Filipino <input type="checkbox"/> Other
	<input type="checkbox"/> Medical <input type="checkbox"/> Healthy Families <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other _____

-----Primary Caregiver-----

Baby resides with (name): (Mother, father, foster parent)		Phone:	
Address:			
Other caregivers: (Daycare, preschool, etc)		Phone:	
Address:			

-----Parents-----

Mother's Name: _____ D.O.B. _____	Father's Name: _____ D.O.B. _____
Ethnicity: _____ Education Level Achieved: _____	Ethnicity: _____ Education Level Achieved: _____
Source of income: _____ Occupation: _____	Source of income: _____ Occupation: _____
Address: _____	Address: _____
Phone: _____ Work: _____	Phone: _____ Work: _____
Does she live in the home: <input type="checkbox"/> Yes <input type="checkbox"/> No	Does he live in the home: <input type="checkbox"/> Yes <input type="checkbox"/> No
Visiting rights if applicable: <input type="checkbox"/> Yes <input type="checkbox"/> No	Visiting rights if applicable: <input type="checkbox"/> Yes <input type="checkbox"/> No
Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No

Siblings: (in the home)      Age      Sex      Health Insurance

		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

# WESTSIDE INFANT-FAMILY NETWORK

	Age	Sex
Other People in the home:		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female

Primary Health care provider: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

**Other Agencies Involved and other services being received (WIN Partner agency, Family Preservation, Regional Center etc):**

- |                                |                                |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
- DCFS Involvement

**Presenting Problem, (What family stressors are there, how it is impacting the parent the parent-child relationship):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Domestic Violence                 | <input type="checkbox"/> Developmental Delay                 | <input type="checkbox"/> Homeless              |
| <input type="checkbox"/> Depression/Post-partum Depression | <input type="checkbox"/> Recent Immigration                  | <input type="checkbox"/> Parent/Child Conflict |
| <input type="checkbox"/> Alcoholism                        | <input type="checkbox"/> Any recent loss or trauma/accidents | <input type="checkbox"/> Isolation             |

**Explain:**

**Medical/Social History (Mother/Caregiver only) Please check all that apply and explain below:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Any Substance Abuse     | <input type="checkbox"/> Chronic Illness:    | <input type="checkbox"/> Any trauma history: |
| <input type="checkbox"/> Extended hospitals stay | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Sexual Abuse        |
| <input type="checkbox"/> Mental Health History   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emotional Abuse     |
|  | <input type="checkbox"/> Other               | <input type="checkbox"/> Physical Abuse      |

**Explain:**

# WESTSIDE INFANT-FAMILY NETWORK

Developmental history of child (Relevant to presenting problem) Please check all that apply and explain below:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Born premature                  | <input type="checkbox"/> Delayed milestone    | <input type="checkbox"/> Toilet trained age: _____        |
| <input type="checkbox"/> In-utero drug exposure          | <input type="checkbox"/> Speech delay         | <input type="checkbox"/> Any hospitalizations             |
| <input type="checkbox"/> Fetal Malnutrition:             | <input type="checkbox"/> Developmental Delay: | <input type="checkbox"/> Socio-emotional milestone delay: |
| <input type="checkbox"/> Small for gestational age       | <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Excessive fussiness              |
| <input type="checkbox"/> Intrauterine growth retardation | <input type="checkbox"/> Autism               | <input type="checkbox"/> Wide- eyed hyper vigilance       |
|  | <input type="checkbox"/> Mental Retardation   | <input type="checkbox"/> Prolonged glazed eyes            |
|  | <input type="checkbox"/> Seizures             | with gaze aversion  |

Explain:

Family Strengths:

Disposition (for clinical coordinator use only):

Send referral to Marta Huertas at [martah@winfamilies.org](mailto:martah@winfamilies.org) or by fax 310-846-4113