UAB EARLY HEAD START PROGRAM
REFERRAL FORM
205.934.5736 (Phone)
205.975.8097 (Fax)

Referrer's Information

Name/Title: _____ Date: _____

Agency: _____ Phone: _____

Caregiver's Information

Primary Caregiver: _____ DOB: _____

Address: _____ Phone: _____

_____

_____ Area: _____

Primary Caregiver's Income: _____

Primary Caregiver is pregnant: ☐ Yes ☐ No *Due date:* _____

Primary Caregiver has diagnosed disability: ☐ Yes ☐ No *Dx:*_____

Children's Information

Children under the age of 3:	***DOB***	***Gender***	***Disability***	***Prematurity***
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Custody Situation ☐ *Parent* ☐ *Grandparent* ☐ *Foster Parent* ☐ *Other Relative*

Identified family challenges ☐ *Homeless* ☐ *At-risk/Open DHR involvement* ☐ *Dual language*
☐ *Maternal substance abuse* ☐ *Domestic violence* ☐ *Mental health concerns* ☐ *Refugee*

Additional Information _

Caregiver Email: _____

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