Nurse-Family Partnership
Helping First-Time Parents Succeed®

REFERRAL FORM

Halifax COMMUNITY COLLEGE

** Person sending the info:

Referring Agency Contact Information

Name:
Agency:
County:
Email:
Phone:
Fax:

Email to: nfp@halifaxcc.edu

Contact info:
NE NC Nurse Family Partnership at HCC
Valerie West
Cell/Text 252-370-2595
Office 252-536-7231
Email nfp@halifaxcc.edu

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We (the referring agency) are referring the following pregnant woman to be contacted by Nurse-Family Partnership and having her consider a nurse to visit her throughout her pregnancy and the baby's first two years.

***** Referral was provided with basic NFP information by agency:** ☒ ***Yes*** ☐ ***No***

Referral's 1st Live Birth: ☒YES ☐NO
Medicaid Eligible: ☒ YES ☐NO
May nurse speak to family? ☒YES ☐NO
May nurse leave a message to call her? ☒YES ☐NO

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Date of referral:
Name of Referral:
Date of Birth:
Due Date:
County of Residence:

Physical Address:
STREET / CITY / STATE / ZIP
(only if different from mailing)
Mailing Address:
STREET / CITY / STATE / ZIP

Home Phone:

Cell Phone:

Alternate Contact Number:
Name/Relationship of alternate:

Race/Ethnicity (if available):
Medical Provider:

NOTES:

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This section NFP use only: ***NFP Referral Intake***

NFP ID Code: _____ *NHV:* _____ *Start Date:* _____

☒ *DMCN* ☒ *Nurse* ☒ *Source* ☒ *Referral Call* ☐ *Referral Letter* ☐ *Misc.:* _____