Resource Mothers Program Referral Form

Richmond City Health District
400 East Cary Street, 3rd Floor
Richmond, VA 23219
Phone: (804) 205-3677 Fax: (804) 371-2208

Date _____

Name: _____ Last 4 digits of SSN: ___ ___ ___ ___

DOB/Age: _____/_____ Teen's Phone Number: _____

Address: _____
Street Address *Apt. #* *Zip code*

Current School: _____ Current Grade: _____

Name of Parent/Guardian: _____ Phone: _____

Alternate Contact: _____ Phone: _____

Email Address for Client: _____

Pregnancy Status

☐ First Trimester (1-13 weeks)
☐ Second Trimester (14-28 weeks)
☐ Third Trimester (29-42 weeks)

Delivery Status

Has teen delivered? ☐ **Y** ☐ **N**
Delivery Date: _____
☐M ☐F Birth Weight _____

Estimated Due Date: _____ Prenatal Care: ☐Yes ☐No

Name of Doctor or Clinic: _____ Phone: _____

Insurance: ☐Yes ☐No Insurance Co. _____ Policy No. _____

Race

☐ African-American
☐ Angle-Saxon/Caucasian
☐ Asian-American
☐ Hispanic Speaks English ☐**Y** ☐**N**
☐ Other

Check all that applies to the enrollee:

☐**Y** ☐**N** Smokes
☐**Y** ☐**N** Drinks alcohol
☐**Y** ☐**N** Involved with the Father of Baby
☐**Y** ☐**N** Currently in treatment?
If in treatment, where? _____

Has the teen had any of the following: IEP, ISP, therapy, counseling, social worker involvement (outside of benefits through DSS)? ☐ **Y** ☐ **N**

OFFICE USE ONLY:

Referral Contact Person: _____ **Phone:** _____

Referral Agency: _____

Date assigned to RM: _____ **1st attempt** _____ **2nd attempt** _____ **3rd attempt** _____

Unable to contact ___ **Declined services** ___ **Inappropriate** ___ **Enrollment Date** _____

Resource Mother assigned _____