******All pages must be completed and sent or referral will not be accepted.******

Martha's Place Referral

Date _____ ☐ English speaking ☐ Spanish speaking ☐ Other language

Is child a ward of the court? ☐ **Yes** ☐ **No** Social Worker _____ Phone _____

Child's Name _____ Child's SS# or Medi-Cal _____

☐ Male ☐ Female Preterm ☐ Yes ☐ No Date of Birth _____ Age _____

Bio Mother's Information: Does Bio mother have any involvement with this child? ☐ Yes ☐ No

Name _____ Phone # _____ Email _____

Bio Father's Information: Does Bio father have any involvement with this child? ☐ Yes ☐ No

Name _____ Phone # _____ Email _____

Foster Parent/Legal Guardian _____ Relationship to child _____
(If different from above)

Address _____ City _____ ZIP _____

Phone Number _____ Email Address _____

Who is legal guardian and/or what is the custody arrangement? ****Please include court documents if applicable.*

_____

Prenatal Exposure, if applicable (specify substances if known): _____

_____

If child is in foster care, please indicate reason: _____

_____

Required Information: **(*Please include City & Zip*)**

Hospital of Birth: _____ **Address:** _____

OB MD/Clinic for Mother's Prenatal Care: _____ **Bio Mother's DOB:** _____

Pediatrician Name/Clinic: _____ **Address:** _____ **Phone:** _____

Previous Pediatrician Name/Clinic (if any): _____ **Phone:** _____

Hospital for ER Visits/Hospitalizations: _____

Medical Specialists: _____

Tri-Counties Regional Center/ Early Start Services:
Has child ever been evaluated by an Early Start Program? ☐ Yes ☐ No

Holder of ED Rights (Name Required): _____

Martha's Place Referral Cont'd

Referring Person: _____ **Phone:** _____

Agency or Relationship to child: _____ **Fax:** _____

Email: _____

Please mark any of the following agencies with which the child you are referring is involved:

- ☐ Child Welfare Services
- ☐ Drug and Alcohol Services/POEG
- ☐ Child Development Resource Center
- ☐ Victim Witness Assistance Center
- ☐ Head Start
- ☐ Kinship Center
- ☐ Women's Shelter
- ☐ CCS
- ☐ CAPSLO Direct Services
- ☐ CAPSLO Homeless Services
- ☐ Family Care Network
- ☐ SART

☐ Public Health - Name of Nurse: _____

☐ School/Preschool (Name required): _____

☐ Daycare Provider (Name required): _____

☐ Other: _____

Please mark any of the following concerns you have about the child:

For Infants:

- ☐ Difficulty with eating/being fed
- ☐ Difficulty with sleep initiation
- ☐ Difficulty with sleep maintenance
- ☐ Resists comfort from caregiver
- ☐ Frequent spitting up
- ☐ Anxious
- ☐ Sensitive to touch/sound
- ☐ Frequent or intense crying
- ☐ Easily startled
- ☐ Arches back when held
- ☐ Limited facial expression
- ☐ Difficulty being soothed
- ☐ Turns head away from caregiver/ difficulty making eye contact
- ☐ Please list any other concerns: _____

For children 1-5 years old:

- ☐ Many Tantrums
- ☐ Difficulty with transitions
- ☐ Depressed
- ☐ Cries often
- ☐ Lack of eye contact with others
- ☐ Overly friendly with strangers
- ☐ Little interest in playing with peers
- ☐ Not easily consoled
- ☐ Anger/Irritability
- ☐ Withdrawn
- ☐ Bedwetting
- ☐ Clingy/doesn't separate
- ☐ Aggression
- ☐ Difficulty with sleep
- ☐ Fearful
- ☐ Few or no friends
- ☐ Impulsivity
- ☐ Hyperactivity
- ☐ Anxious
- ☐ Developmental Delays
- ☐ Please list any other concerns: _____

If this is a referral from Social Services, please upload form to the MH Referral/Eligibility Assessment Database.

If referring from an outside agency, please fax to Martha's Place at 781-4962.

For questions please contact: **Laura Ottrando, RN, PHN at (805)781-4964**