



Benton-Franklin Health District

Safe Babies, Safe Moms

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Prevent Promote Protect

Referral Information Form

Date of Referral: _____

Client ID: _____

(In office only)

Person and Agency making the referral: _____ Phone: _____

Last Name: _____ First Name _____ DOB: ____/____/____

* Must be 18 years of age or older to qualify for this program

Address: _____

City _____ Zip Code _____

Phone: _____ Message Phone: _____

Does this person or her children currently have a medical coupon? Yes No

Child Information

Is this person Pregnant? Yes No Due Date: ____/____/____ OB/GYN: _____

If **not** Pregnant, what is the name of youngest child? _____ DOB: ____/____/____

Placement of child _____

Any Children's Administration Involvement? Yes or No Name of SW: _____

Child's ID : _____ (in office only)

Family Information

Name and DOBs of person's other children

Child: _____ DOB: ____/____/____ Placement: _____

Is there a significant other involved? Yes No Name: _____

Drug History Information

Date of Last use? ____/____/____ Drug/s used: _____

Has this person had an assessment? Yes No Where? _____

Is this person currently in treatment? Yes No Where? _____

Comments

Referral taken by: _____

Enrolled/Closed Date _____ CM assigned _____