Pregnancy and Parenting Education Programme

Referral Form

Full name: *(Attach patient label. If no patient label, please complete required fields).* **Name:** **Address:** **Phone number:** **Date of Birth:** **Email:** **Ethnicity:**			**EDD:** / / **Gestation:** **First baby?** O YES O No If no, parity: **Education requested:** O Antenatal O Postnatal
Referring for:	O Community class		O Kaupapa Māori Wānanga
	O Home visit - **SEE STRICT CRITERIA BELOW**		O Pasifika programme
Preferred:	Date:	Time:	Location:

Criteria for home visit:

1. Falls within the following priority population groups:

O Young/teen parent O Māori O Pasifika O Former refugee, less than 2 years
O New migrant, less than 2 years O Other – must be extenuating circumstances, eg mental health, homeless

2. Identified needs:

O Low income O Low level education O No or limited transport O Limited family or social support
O Poor housing O High household occupancy O Single parent O Mental health concerns

MUST MEET AT LEAST 4 OF THESE CRITERIA.

3. O Will not attend a community class. State reason:

4. O Will commit to an appointment time for a home visit.

5. O Home environment is safe for the educator to visit.

Additional comments:	
Eligible for healthcare services?	O Yes O No
Is English a second language? O Yes O No	**Language spoken:**

Referrer details:	Name:	Position:
	Location: O ADHB employed LMC O Self-employed LMC O Other, please state:	Name of LMC if not referrer:
	Email:	Contact number:

Referral date:		**Level of priority action:**	O Low O Medium O High
Email referral to:	Leah Broughton-Couch, Programme Manager - lbroughton@adhb.govt.nz		

Note to referrer: For enquiries please email the Programme Manager. Please file the original form in patient notes.

REVISED: 26NOV2018