



Blake Foundation

TUCSON NURSE-FAMILY PARTNERSHIP / RAISING HEALTHY KIDS REFERRAL FORM

To: Casa de los Niños

Date of Referral: _____

Agency Contact: Rosie Dyer RN BSN:
Nurse-Family Partnership
Raising Healthy Kids
Contact Phone Number: 520-624-5600 x 506
Fax Number: 520-623-2443
Email:rosied@casadelosninos.org

Agency Contact: _____

Referral Name: _____

Referral Phone Number: _____

Referral Email: _____

PLEASE CHECK ONE:

Nurse-Family Partnership:

To qualify for the program, the mom must be a first time mother, less than 28 weeks pregnant and meet the financial income requirements. Participation in the program involves nurse home visits through pregnancy until the baby is two years old. The nurse will perform developmental and health assessments, assist the mom with bonding and attachment, and provide education on parenting skills. In addition, the nurse will assist the mom with referrals for support services and identify ways to continue her education and set goals for the future.

Raising Healthy Kids:

To qualify for the program, the family must have children under the age of five. Participation in the Raising Healthy Kids Program involves a Community Health Specialist that makes visits in the home working with families on bonding and attachment, child development activities, parenting skills and school readiness. In addition, the Community Health Specialist will assist the family with personal goals, community resources, and support services as needed.

Both programs require clients to live in the following zip codes to qualify: 85701, 85705, 85707, 85708, 85710, 85711, 85712, 85713, 85714, 85715, 85716, 85719, 85745, 85746, 85756, 85757.

Parent Name: _____

DOB: _____

Address: _____

Zip Code: _____

Phone: _____

Cell No.: _____

Name and DOB of Children:

Pregnancy Due Date: _____ Language: _____ Potential Appoint. _____ Best Time to Call: _____

The parent has been informed about the Nurse-Family Partnership Program and the Raising Healthy Kids Program and gives their permission to be contacted by a Registered Nurse or Community Health Specialist.

Additional information can be provided through the contact information listed above- phone, fax or email.

Consent for Referral (optional): _____

Office Only: Date assigned: _____ Staff assigned: _____ Intake Date: _____