Healthy Babies Referral Form

Date of Referral: _____

First Name: _____ **Middle Initial**: ____ **Last Name**: _____**Date of Birth**: _____

Street Address: _____ ____ **Apt**: _____**City**: _____ ___ **Zip**: _____

Phone: _____ **Message Phone**: _____ **Email**: _____

Are you pregnant? ☐ YES ☐ NO **If yes, what is your due date?** _____

If not pregnant, what is your baby's date of birth? _____

How many times have you been pregnant? _____ **How many babies have you delivered?** _____

Are you under 18 years of age? ☐ YES ☐ NO **If yes, are your parents/guardians aware of this pregnancy?** ☐ YES ☐ NO

If pregnant; have you been to a doctor for this pregnancy? ☐ YES ☐ NO

What clinic provides medical care for you (pregnant) or your child (delivered)? _____

How did you hear about our program? _____

Notes/Comments: _____

_____

For Referral Source & Program Use Only

Referred by: ☐ Self ☐ Parent/Guardian ☐ Agency ☐Friend ☐Other If other, please list: _____

Referring Party Name _____ Phone: _____

Please click Submit Form when finished. If you have trouble submitting, please save the file and email to healthy.babies@sedgwick.gov or mail referral to:

Healthy Babies
Sedgwick County Division of Health
1900 E. Ninth St. N.
Wichita, KS 67214

Phone: (316) 660-7433
Fax: (316) 660-0997
Email: healthy.babies@sedgwick.gov

Submit Form