Birth Support, Education & Beyond

Perinatal Support Services
Referral Form

Date of Referral:

Email all referrals securely to:
traci.mccomiskey@bsebct.org

Client Information:

Name:
(first/last)

DOB:
(mm/dd/yyyy)

Age:

Address:
(apt./#, street, city, state, zip)

Phone: Ok to text? Yes☐No☐ Ok to leave message? Yes☐No☐

Email: Primary Language:

Race: American Indian/Alaska Native☐ Asian☐ Black/African American☐ Alaskan Native☐
Caucasian/white☐ Native Hawaiian/other pacific Islander☐ Other/Undetermined☐

Ethnicity/Culture: Hispanic or Latino☐ non-Hispanic or Latino☐

Any Cultural or Religious Beliefs the client would like us to be aware of?

Parent/Guardian:
(if applicable, first/last name)

Phone:

Email:

Pregnant? Yes☐No☐

Estimated Due Date:

High Risk Pregnancy? Yes☐No☐
Reason:

First Baby? Yes☐No☐

Parenting? Yes☐No☐

Child:
Full Name

DOB:
(mm/dd/yyyy)

Child:
Full Name:

DOB:
(mm/dd/yyyy)

Children being cared for by client? Yes☐No☐

Active DCF involved Client? Yes☐No☐
SW Name, phone, email, office:

Active DCF involvement for Children? Yes☐No☐
SW Name, phone, email, office:

Reason for Referral

History of complex trauma, mental health diagnosis, domestic violence, minimal support systems, out of home placement/foster-care, any concerns etc.

Any added information to help us support this client:

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Social Service/Assistance Programs
(check all that apply)

SSI or SSDI ☐ WIC ☐ SNAP ☐ Care4Kids ☐ Section 8 Housing ☐ Cash Assistance (TANF, SAGA, State supplement) ☐ Other:

Client's Primary Health Insurance

Subscriber's Name: Subscriber's DOB:

Relation to Client: self ☐ spouse ☐ child ☐ Subscriber's Employer:

Policy #: Group#

Any secondary Insurance? Yes ☐ No ☐ Policy# Group#

Referring Provider/Agency

Referring Provider: (name/title) phone: email:

Referring Provider NPI # _____ Name of Agency: (Hospital/Program/School/Practice, Etc.)

Address: (Street, City, State, Zip)

Consent to Refer/Release of Information

Yes, I am interested in services provided by BSEB-Birth Support, Education & Beyond. I understand that the home visiting program will contact me to schedule time to meet to discuss services and support available to me.

I, (Name of client or guardian), give my permission authorization to the release and exchange information for the purpose of referral, coordination of care, service eligibility determination, and continuity of support through BSEB – Birth Support, Education & Beyond, Inc.

I understand that information shared under this authorization will be handled with respect and in accordance with applicable confidentiality laws including HIPAA and state protections.

I understand that BSEB does not diagnose or treat medical conditions but provides supportive, educational, and community-based perinatal services.

Printed Client/Guardian Name:

Client/Guardian Signature: **Date:**