Community Health Worker Services Referral Form

The Neighborhood Center, Inc.
628 Mary Street Utica, NY 13501
315-801-5014 (Oneida County) or 315-801-5011 (Herkimer County)
Fax # 315.272.2710

Date:_____

Name: _____ _____ _____
Last **First** **DOB**

Address: _____**City:**_____**Zip**:_____

Phone Number:_____ **Alternate Number:**_____

Alternate Contact: _____
Name/Phone Number/Relationship

Primary Language: _____

Health Insurance: Yes☐ **Type and Number** _____
No☐

Is Client aware of referral to CHWS? ☐ YES ☐ NO If no, why? _____

Pregnant? ☐ YES ☐ NO **EDD**_____ **Parenting?** ☐ YES ☐ NO

Reason for Referral:

☐ Parenting Resources	☐ Health Insurance
☐ Safe Sleep Education	☐ Primary Care Physician/ OBGYN
☐ Breastfeeding	☐ Prenatal Planning
☐ Dental Health/Dentist	☐ Post-Partum Care/Support
☐ Home Safety	☐ Family Planning
☐ Nutrition	☐ Birth Control
☐ TANF/Food Stamps (SNAP)	☐ Substance Use-Alcohol/Drugs/Smoking
☐ Infant Care Resources	☐ Physical/Emotional Abuse
☐ Resource Information	☐ Counseling Services

☐ Other Reason:
_____

_____

Referral Source: _____ Date: _____

CHW: _____ Date: _____