

the family resource center

123 Main Street Gorham, NH 03581 (603) 466-5190 www.frc123.org

Date of Referral: _____
 Type of Service: Home Visiting Case Management Classes/Groups Caregiver/Kinship Support
 (Check all that apply)

Parent/Caregiver Name: _____ DOB: _____

Address: _____

Phone: _____ Work/Cell: _____ Email: _____

Name of PCP: _____

Everyone in the home: <u>Name(s)</u>	<u>D.O.B.</u>	<u>M/F</u>	<u>Relationship</u>

Reason for Referral (Current Needs)check all that apply

- Parenting Skills (ie.discipline)
- Budgeting/Organizational Skills
- Assistance with Community Resources
- Child Care Needs/Concerns
- Other _____

- Pre-natal _____ Due Date
- Stress Management
- Anger Management
- Play Groups
- Home Making

Current Family Stressors (check all that apply):

- Recent/Expected Birth
- More than 1 child under 3
- Child(rens) Development
- Parent with Health Concerns
 - Time limited
 - Chronic
- History of Alcohol/Drug Abuse
- DCYF involvement in last 12 months
 - Assessment Only
 - Founded

- Teen or Single Parent
- Mental Health Concern
- Physical, Social, Cultural Isolation
- Traumatic Family History
 - (ie: sexual abuse/domestic violence)
- Unsafe/Health conditions in home
 - (inadequate food, clothing, shelter)
- Kinship
 - Home Visiting
 - Case Management/Concrete Supports
- Domestic Violence Concerns

Family member currently/formerly in the military

Other Agencies currently involved: _____

Mental health concerns; Diagnosis _____

PHQ – 2	Not at all	Several Days	More than half the days	Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed or hopeless?	0	1	2	3

Additional information: _____

If DCYF Referral, is there suspected abuse? Y N

Infant Safe Plan of Care Y N

Client Services/DFA/TANF Y N

Referring Agency: _____ Name (print): _____ Phone: _____

I give permission to contact referring agency if checked.
Family Signature:
