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:__________________ Race:___________ Ethnicity:___________ Primary Language:____________

Everyone in the home:

Name(s)	D.O.B.	M/F	Relationship

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:

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PLEASE FAX REFERRAL TO FAMILY RESOURCE CENTER 603-466-9022 OR SEND EMAIL TO: familysupport@frc123.org

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