

Healthy Babies Healthy Children Program Referral Form

Referral information

Required fields are marked with asterisks (*)

Email referral form to hbcintake@hpph.ca

Fax 519-271-8243 or toll-free 1-855-271-8243

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Purpose

Healthy Babies Healthy Children (HBHC) is a free, voluntary program for expectant parents and families with children from birth up to transition to school.

HBHC referrals can be made as a self-referral or a professional referral from a healthcare or service provider.

Eligibility:

- expecting a baby; or
- parenting a child from birth up to transition to school age; and
- living in Stratford, St. Marys, Perth or Huron County (area served by HPPH)

Referral source*

†Include contact information of person making referral

Self-referral

Name _____

Healthcare provider†

Organization _____

Service provider†

Other†

Email _____ Phone _____

Client information

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First name* _____ Last name* _____

Date of birth (yyyy/mm/dd)* _____

Phone* _____ Email* _____

Address (911)* _____

City or town* _____ Municipality* _____

Postal code* _____

Preferred method of contact (public health nurse will contact you/client after receiving referral)*

Phone

Text

Email

Referral type*

Prenatal (expecting a baby)

Postpartum

(baby is newborn to 6 weeks old)

Early identification

(child is 7 weeks to 6 years old)

Additional family members (if applicable):

1. First name _____ Last name _____

Date of birth (yyyy/mm/dd) _____

2. First name _____ Last name _____

Date of birth (yyyy/mm/dd) _____

3. First name _____ Last name _____

Date of birth (yyyy/mm/dd) _____

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Client information

Additional family members:

4. First name _____ Last name _____

Date of birth (yyyy/mm/dd) _____

5. First name _____ Last name _____

Date of birth (yyyy/mm/dd) _____

Reason for referral (select all that apply)*

Concerns with child development

Concerns with parenting

Financial and/or housing concerns

First time parent

Infant feeding concerns

Newcomer to Canada

Parent learning challenges

Parent mental health challenges

Parent under 18 years of age

Relationship strain, single/solo parent,
or lack of social supports

Substance use

Prefer to discuss with the nurse when
contacted

Other, specify:

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Primary care provider (family doctor or nurse practitioner)

First name _____ Last name _____

Phone _____

Other services you/client are involved with*

Child and Parent Resource Institute

Children's Aid Society

Huron Perth Centre

Ontario Disability Support Program

Ontario Works

Other (e.g. medical specialist, social
worker/counsellor)

smallTALK

Not applicable

How did you/client find out about the home visiting program?*

Calling All Three Year Olds (CATYO)

EarlyON Child and Family Centre

Friend or family member

HBHC program pamphlet or poster

Hospital

Huron Perth Public Health website

OBGYN or midwife

Primary care provider

Acknowledgement

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I acknowledge that the information provided in this form is correct. I understand that I/client will be contacted by a public health nurse. *

Date (yyyy/mm/dd)* _____

Personal information

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Personal or personal health information on this form is collected under the authority of the *Health Protection and Promotion Act* and applicable privacy legislation. This information will be used for the delivery of public health programs and services and may be used for evaluation or statistical purposes. Any questions about the collection of this information should be directed to the Privacy Officer, Huron Perth Public Health, 1-888-221-2133 or email privacy@hpph.ca.