Felton institute TAPP AND YFRC

REFFERAL FORM

TEENAGE PREGNANCY & PARENTING PROGRAM (TAPP)
YOUNG FAMILY RESOURCE CENTER (YFRC)

CLIENT CONSENT *To be completed by the client or their guardian, if applicable.*

☐ *I consent to share my information, or the information of the minor in my care, with Felton Institute's TAPP/YFRC program and related services for the purpose of referral.*

Signature : ______________________ **Date** : ______________

CLIENT PERSONAL INFORMATION *Complete the fields to the best of your knowledge.*

First Name : ☐ **Last Name** : ☐

Date Of Birth : __________ **Client's Age** : ☐ **Is the Client in School?** : ☐ Yes ☐ No

School Attending : ☐ **Grade Level** *(or highest level completed)* : ☐

Race/Ethnicity : ☐ **Gender** : ☐

Monolingual Spanish Speaker? : ☐ Yes ☐ No **Primary Language Spoken** : ☐

CLIENT CONTACT DETAILS

Address : ______________ **Apt#** : ______ **City** : ____________ **Zipcode** : ______

Phone Number : ______________ **Email** : ______________

Who lives in the client's household? *(parent, relative, guardian partner, foster home, independently, other)* : ☐

CLIENT'S EMERGENCY CONTACT DETAILS

Full Name : ______________ **Relationship** : ______________

Phone Number : ______________ **Email** : ______________

CLIENT'S HEALTH AND MEDICAL INFORMATION

Primary Care Provider's Full Name : ______________________________

Address : ______________________ **City** : ______________ **Zipcode** : ________

Phone Number : ______________________ **Email** : ______________________

Does the client have any medical conditions or require specific care? : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*

If yes, please describe the condition and required care :

Are they currently attending prenatal care appointments? : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*

In the section below, identify if there is a history of any of the following :

☐ *Alcohol/Substance Overuse* ☐ *Anxiety* ☐ *Depression* ☐ *Domestic Violence* ☐ *Eating Disorder*

☐ *History of Trauma* ☐ *Posttraumatic Stress* ☐ *Psychiatric Hospitalizations* ☐ *Self-Harm*

☐ *Suicidal Ideations or Attempts* ☐ *Other:* ______________________

Any additional comments on the client's mental health or substance use history? if applicable :

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FAMILY AND SUPPORT SYSTEM

Primary Guardian Name *if applicable* : ______________________ **Relationship** : ______________

Who are the key people in the client's support system, and what role do they play?

Is the partner engaged in supporting the pregnancy and/or parenting? : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*

Partner's Age : __________ **Partner's Level of Involvement** : ☐ Low ☐ Med ☐ High ☐ Unknown

CLIENT PREGNANCY / PARENTING INFORMATION

Is the Client Pregnant? : ☐ Yes ☐ No **Estimated Due Date (EDD)** : ______________________

Stage of Pregnancy : *If the client is currently pregnant.*

☐ 1st trimester. Conception - 12 weeks ☐ 2nd trimester. 13 - 27 weeks ☐ 3rd trimester. 28 - 40 weeks

Describe any pregnancy complications or concerns, *If applicable* :

Was the pregnancy planned? ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*

Was the client on birth control at time of pregnancy? ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*

First Time Mother? : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*

Is the Client Parenting? : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*

IF PARENTING

Child's Name :	**DOB :**	**Gender:**
Child's Name :	**DOB :**	**Gender:**

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CLIENT'S PARENTING READINESS & GOALS *Please enter "N/A" for any items that are unknown*

What specific parenting support services are they seeking? *e.g., parenting skills, life skills, financial literacy*

Do they have prior parenting experience? *Are there any successes or difficulties they'd like to share?*

What are the client's goals? For themselves, their pregnancy, their child/children and their future?

QUESTIONS

1. **Are the client's parents or legal guardian aware of the pregnancy?** : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*
2. **Is the client served by the Nurse-Family Partnership program?** : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*
   If yes, please provide the nurse's contact information.
   Nurse's Full Name : ______________________ *Phone* : ______________________
3. **Is the client a Cal-Learn participant?** : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*
4. **Does the client have child development questions?** : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*
5. **Is the client interested in Felton's child development classes?** : ☐ *Yes* ☐ *No* ☐ *Unknown* ☐ *N/A*
6. **Is the client interested in high school or a GED?** : ______________________

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REASONS FOR REFERRAL TO TAPP PROGRAM

What specific needs or challenges does the client have? *e.g., parenting, education, employment, mental health support.*

Based on your observations, what issues or concerns need addressing in the client's situation?

REFERRED BY

First Name : ______________________ **Last Name** : ______________________

Job Title : ______________________ **Relationship to Client** : ______________________

Email : ______________________ **Phone Number** : ______________________

Agency Name : ______________________ **Agency Website** : ______________________

TAPP OFFICE USE ONLY

Referral taken by :

Date : ______________________

Referral assigned to :

Date : ______________________