Interior Health

Patient Name *(last)* ______

(first) ______

DOB *(dd/mm/yyyy)* ______

PHN ______

HEALTHY FROM THE START
Program Referral

☐ **Client aware of referral & consents to contact**

Expected Delivery Date *(dd/mm/yyyy)*

Gravida	Para

Address ______

OK to:

☐ Phone and leave a message Preferred # ______

☐ Text Preferred # ______

☐ Email ______

☐ Alternate contact name ______ Phone ______

Strengths/supports identified by the mother/family that will support them in their role as a parent(s)

Would the client benefit from additional information or support in the following areas?

☐ Pregnancy and parenting

☐ Finances and housing

☐ Relationships, social supports or safety

☐ Mental health and wellness

☐ Past or present experience with substance use

☐ Tobacco/vaping products

Additional comments:

Referred by *(signature and title)*	Office Stamp Here
Date *(dd/mm/yyyy)*	
Fax	
Phone	

Please fax completed referral to 250-868-7809

For inquiries call 1-855-868-7710 or email HealthyFromTheStart@interiorhealth.ca

Healthy From The Start summary

Date (dd/mm/yyyy)	Time (24 hour)	Signature	Designation
/ /			

Client notified that this personal information is collected under and is subject to the provisions of the Freedom of Information and Protection of Privacy Act (FIPPA)

Permanent part of the health record