



HEALTHY BABIES HEALTHY CHILDREN PROGRAM REFERRAL FORM



MOTHER'S NAME	DATE OF BIRTH
ADDRESS	DUE DATE
PHONE NUMBER	
FATHER'S NAME	DR./MIDWIFE

CHILDREN:

NAME	DOB	NAME	DOB

Areas of Concern (please circle): Single parent, first-time parent, finances, housing, mental/emotional health, lack of support(s)/isolation, family dynamics, substance abuse, learning ability/education.

Additional Comments:

Date _____ Agency _____

Completed by _____ Phone No. _____

Client has given permission for transfer of this information to the Health Unit YES

To make a referral:

Phone: 625-8814
 Fax: 628-8664
 Website: www.tbdhu.com

Information is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, as amended and in accordance with the Municipal Freedom of Information and Protection of Privacy Act R.S.O.1990. This information will be used for screening, assessment, management, treatment, and reporting purposes. Questions regarding the collection of this information should be addressed to the Freedom of Information Co-ordinator, Thunder Bay District Health Unit, 999 Balmoral Street, Thunder Bay, Ontario. P7B 6E7. Telephone (807) 625-5965.