Alberta Health Services

Family Health Home Visitation Referral

Once completed submit by email to FHHV@albertahealthservices.ca

Demographics *(Mothers information)*		
Surname of Mother	Mother's Full Given Name (if Known)	
Date of Birth *(yyyy/mm/dd)*	Mother's Age *(Years)*	Phone Number
Home Address		

Service Area

☐ Cardston ☐ Coaldale ☐ Crowsnest Pass ☐ Ft. Mcleod ☐ Lethbridge

☐Magrath ☐ Milk River ☐ Picture Butte ☐ Pincher Creek ☐ Raymond

☐ Taber ☐ Vauxhall ☐ Other_____

Newborn Information		
Surname of Newborn	Newborn Full Given Name *(if Known)*	
Date of Birth *(yyyy/mm/dd)*	Gender	Estimated Due Date *(if pregnant)*
Baby for Adoption ☐ Yes ☐ No ☐Unknown	Child Protective Services Involved ☐ Yes ☐ No ☐Unknown	

Universal Newborn Screening with comments

Late or No prenatal Care, Poor Compliance ☐ Yes ☐ No ☐ Unknown

Therapeutic Abortion, Unsuccessfully Sought or Attempted ☐ Yes ☐ No ☐ Unknown

Relinquishment for Adoption Sought or Attempted ☐ Yes ☐ No ☐ Unknown

Education under 12 Years ☐ Yes ☐ No ☐ Unknown

No Transportation ☐ Yes ☐ No ☐ Unknown

Limited Access to Phone ☐ Yes ☐ No ☐ Unknown

Single or Current Live-in Partner less than 12 Months Duration ☐ Yes ☐ No ☐ Unknown

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Universal Newborn Screening with comments continued
Partner Unemployed ☐ Yes ☐ No ☐ Unknown
Inadequate Income Per Family ☐ Yes ☐ No ☐ Unknown
Unstable Housing *(Moved more than once During Past Year)* ☐ Yes ☐ No ☐ Unknown
Inadequate Emergency Contacts ☐ Yes ☐ No ☐ Unknown
Marital or Family Problems ☐ Yes ☐ No ☐ Unknown
Current/History of Depression Requiring Medication/Hospitalization ☐ Yes ☐ No ☐ Unknown
History of Psychiatric Hospitalization ☐ Yes ☐ No ☐ Unknown
Any Use of Alcohol, Street Drugs or Solvents During Pregnancy ☐ Yes ☐ No ☐ Unknown
Additional Comments

Is the client aware and agreeable to the Home Visitation Program Referral
☐ Yes
☐ No

Submit by E-mail