REFERRAL for COMMUNITY HEALTH WORKER CONTACT

Referring Agency:		
Date of Referral:		**Agency Phone:**
Name of Contact:		**Email:**
HIPPA Release Attached? ☐Yes ☐No		
CLIENT INFORMATION		
Client's Name:		**Age:**
Street Address:		**Phone:**
City:	**State:**	**Zip:**
Email:		
How do you prefer to be contacted?	☐ Phone ☐ Text ☐ Email	**Race:** **Hispanic:** ☐ Y ☐ N
Best time to reach you by phone or text (Hours/ Days)?		
CLIENT STATUS		
Are you? ☐ **Currently pregnant**_____ **(Estimated Due Date)** ☐ **Recently gave birth** _____ **(Delivery Date)** ☐ **Child under age 1** _____ **(Child's Age)**		
By signing below, you are giving permission for a Stark County THRIVE or Moms & Babies First (formerly KOBA) Community Health Worker to contact you.		
Client Signature: _____ **Date:** _____ **If a minor, Parent/Guardian Signature is required:** **Parent/Guardian Signature (if applicable):** _____ **Date:** _____		
Please include any Referral Notes or Participant Needs here:		

Referral Received by:		**Date:**
Referral Assigned to:		
Referral Outcomes:		

Rev. 3-2-22 ss

FAX completed referral to:

Attention: Access Health Stark County via secure fax # 330-437-3717
Email: Stacy Kelly- Clinical Manager (Skelly@accesshealthstark.org)
Sonya Swift- Admin Asst. (Sswift@accesshealthstark.org)

Access Health Stark County Office # 330-437-3715