GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Date:_____

If you have questions about making a referral, please call the Family Center at 422-8209 option 3.
To make a referral: Fax the completed form to (603) 422-8219 or email completed forms to fcreferrals@goodwinch.org

| **Identified adult client for services:** Name: | | | DOB: |
|---|---|---|---|
| Home address: | City | State | Zip code |
| Primary phone: ☐Call ☐Text | | Interpreter needed: ☐Yes ☐No Language: | |

**Others in the Home:**

| | | |
|---|---|---|
| Name: | DOB: | Relationship to client: |
| Name: | DOB: | Relationship to client: |
| Name: | DOB: | Relationship to client: |
| Name: | DOB: | Relationship to client: |
| Name: | DOB: | Relationship to client: |

**Priority Considerations:**

☐DCYF Involvement within 12 months ☐Need for prenatal care ☐Safety concerns ☐SUD concerns

**Reasons for Referral (please check all that apply):**

| | | | |
|---|---|---|---|
| ☐ACERT | ☐Behavioral Health | ☐Childcare | ☐Concrete Supports |
| ☐Developmental Screenings | ☐Domestic Violence concerns | ☐Financial Education | ☐Financial Resources |
| ☐Health Services | ☐Home Visiting Services | ☐Kinship Navigation | ☐Parent Education |
| ☐Playgroup | ☐Resource and Referral | ☐SUD/Recovery Support | ☐Support Group |

Please explain checked boxes, use back if necessary:_____

_____

_____

_____

_____

**Other agencies involved**:_____

Referring agency:_____ Phone: _____

Contact person:_____ Is client aware of referral: ☐Yes ☐No

**Office use only:** Date received:_____ Quickbase number:_____