Parents as Teachers
Agency Referral Form

Please return to: Family Services Coordinator
pat@alamancechildren.org or fax to 336-226-1152

Referral Source/Agency:_____Date:_____

Parent's/Guardian's Name: _____ Date of Birth:_____

Family Address: _____

City: _____ State: NC Zip: _____

Contact Information (Phone #s): (H)_____ (C)_____

Assigned School District: _____Primary Language: _____

Children's Names (Five Years of Age or Under):

Does the child attend a licensed child care?

1. _____Date of Birth:_____ Child Care*: Yes No
2. _____Date of Birth:_____ Child Care*: Yes No
3. _____Date of Birth:_____ Child Care*: Yes No

Prenatal referral (*circle one*): Yes No

Significant issues, concerns or barriers to be addressed by assigned Parent Educator:

_____

_____

_____

Needs Assessment: (*please check all that apply*)

National High Needs Characteristics			
□ Teen Parent (under age 20)	□ Court Appointed / Foster	□ Child with Disabilities	□ Parent with Disabilities
□ Transient/Homeless	□ Suspected Abuse/Neglect	□ Low Income	□ Low Birth Weight
□ Low Education	□ Substance Abuse	□ Incarcerated Parent	□ Death in Immediate Family
□ Military Family	□ Parent Mental Illness	□ Rec Immigrant / Refugee	□ Domestic Violence
Additional Demographic Characteristics			
□ One-Parent Household	□ ESL	□ Mental/Social Services	□ CDSA referral
□ 3 or more children under 5	□ Adoptive Parent	□ Relative Primary Caregiver	□ Serious behavior concerns
□ All Guardians Work Outside	□ First Time Parents	□ Parent Foreign Born	□ Underinsured
	□ No Health Insurance	□ Subsidy/Medicaid	□ CSC/Health Department

Referral Source Contact Information: Name, Position, Email Address and Phone #.

Name:_____Position:_____

Email:_____Phone #:_____

For Office Use Only

Form Received Date: _____

Date Family Contacted Regarding Referral: _____

Date Referral Assigned: _____Assigned Parent Educator: _____

Family enrolled: _____ **Family declines services:** _____ **Date Contacted:** _____