

**Public Health
EARLY YEARS CLIENT REFERRAL FORM**

Central Zone: earlyyears cz@nshealth.ca **Eastern Zone:** earlyyears ez@nshealth.ca **Northern Zone:** nzeynurses@nshealth.ca **Western Zone:** earlyyears wz@nshealth.ca
Fax: 902-481-5904 **Fax:** 902-563-8401 **Fax:** 902-667-2273 **Fax:** 902-742-5064

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|--|--|--|--|
| Client verbally consents to referral: <input type="checkbox"/> Yes <input type="checkbox"/> No | | *Public Health will not contact if the client is unaware of the referral | |
| Client Chosen Name: _____ | | | |
| Client Legal Name (if different): _____ | | | |
| Pronouns (if disclosed): _____ | | | |
| Health Card Number: _____ | | Date of Birth (YYYY/MON/DD): _____ | |
| Language Preferred: _____ | | Needs an Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Address: _____ | | Telephone Number: _____ | |
| | | Email: _____ | |
| | | Preferred Method for Contact: _____ | |
| Prenatal | | Postnatal | |
| Due Date (YYYY/MON/DD): _____ | | Infant Name: _____ | |
| Gestation at time of referral: _____ | | Infant DOB (YYYY/MON/DD): _____ | |
| Gravida: _____ Parity: _____ | | Infant HCN: _____ | |
| First time parenting: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| | |
|--|-------------------|
| Health History/Risk Factors: | |
| <input type="checkbox"/> Mental health (anxiety, depression, etc.) <input type="checkbox"/> Edinburgh Postnatal Depression Scale (EPDS) score: _____ <input type="checkbox"/> History of trauma/abuse <input type="checkbox"/> Intimate partner violence <input type="checkbox"/> Financial/housing issues <input type="checkbox"/> Food security concerns <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Lack of support/isolation | |
| Substance Use (past or current): | |
| <input type="checkbox"/> Tobacco <input type="checkbox"/> Vaping <input type="checkbox"/> Cannabis <input type="checkbox"/> Alcohol <input type="checkbox"/> Other: _____ | |
| Education: | |
| Highest level of education completed: _____ | |
| Infant Feeding Support: | |
| <input type="checkbox"/> Breast/chest feeding <input type="checkbox"/> Combination feeding <input type="checkbox"/> Formula feeding <input type="checkbox"/> Infant feeding education | |
| Additional Information/Comments/Concerns: | |
| | |
| Name of Primary Care Provider (if other than referral source): _____ | |
| Contact Number: _____ | Fax Number: _____ |

For more information about Early Years, Public Health: Early Years | Information and Wellness Portal

Name of Referring Clinic/Provider: _____ Date (YYYY/MON/DD): _____
 Referral Contact Number: _____ Signature: _____

