

Better Beginnings

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Better Beginnings Referral Form

REFERRAL SOURCE

PERSON MAKING REFERRAL

Name: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

FAMILY INFORMATION

ADULT TO BE INVOLVED IN SERVICES

Name: _____ DOB: _____

Relation to Child: _____

YOUNGEST CHILD IN FAMILY

Name: _____ DOB: _____

CONTACT INFORMATION

Address: _____

Phone: _____

REASONS FOR REFERRAL

RISK FACTORS (Check all that apply):

IN THE CHILD:

- Fetal drug/alcohol exposure
- Shy temperament
- Chronic medical disorder

- Premature birth or complications
- Neurological impairment
- Psychiatric disorder

- "Difficult" temperament
- Developmental delays/Low IQ < 80
- Repeated aggression

IN THE FAMILY:

- Poverty
- Large family (4 or more children)

- Siblings within 2 years of child
- Parent/Caregiver with substance abuse

- Parent/Caregiver with criminality
- Parent/Caregiver with mental illness

EXPERIENTIAL:

- Poor infant attachment to parent/caregiver
- Separation/Divorce/Single Parent
- Witness to extreme conflict/violence
- Removal from home

- Long term absence of caregiver in infancy
- Substantiated neglect
- Sexual abuse
- Physical abuse

- Negative parent/caregiver-child relationship
- Frequent family moves
- Teen pregnancy

REASONS FOR REFERRAL NARRATIVE
