RAMSEY COUNTY

Mothers First Referral Form
Email form to: SSD.MOTHERSFIRST@RAMSEYCOUNTY.US

Mothers First Does NOT accept Handwritten referrals

Participant Name:______________________ Phone: ___________________ Birthdate ________________CCI#: ____________

Physical Address: ____ (please include City/State/Zip)

Email Address: ____

Emergency Contact person:____________________________ Emergency Contact person phone number:____________________

Participant Race:___________ Preferred Language spoken:_________________ Does the participant need an interpreter:________

Does the participant identify as Indigenous?_________ Are they registered? If so what tribe? _______________________________

Has the participant ever worked with MF before? __________________ If so when:_________________________________

Is the participant currently pregnant? ______________ Due Date:____________ Birthing Hospital Preference _______________

Is the participant receiving prenatal services?__________ If so, where?___________

Is the participant interested in Doula support?________ Is the participant interested in Public Health Nurse support?________

Does the participant have an open CPS case?__________ CPS worker name______________ CPS worker number___________________

Child's Name	DOB	Age	Do they have active insurance?	Do they have their immunization?	In out of home placement?	Need of Birth Certificate?	Need of SS Card?

Does the participant need a copy of their Birth Certificate? _________Does the participant need a copy of their Social Security Card? ________

Is the participant receiving general assistance or any other financial support from Ramsey County? _____________

FAS Case number: __________ Is the participant currently working? _________ Is the participant on unemployment?________

Date of last Substance use assessment: ________ Last date of use:__________ Medication to treat substance use:____________

Does the participant need a substance use assessment? __________ Participant's substance(s) of choice ___________________

Is the participant currently in treatment? _________ If so what location? __________________________

Does the participant have health insurance? ______ Insurance Provider: ______________ Health insurance #________________

Does the participant need a mental health assessment? ________ Is participant currently in therapy? _____Mental Health Provider:__________

MH Provider Location:_______________ MH phone number:__________________ MH Diagnosis _____________

Is this participant currently on probation?________ Probation officers name:______________________ PO Phone Number________________

PO County___________________ Does participant have any current pending charges? ______ If so, what are they? _______________________

Is the participant working with other providers/ professionals?____

What are you/ participant hoping to gain working with Mothers First? ____

Please add any additional information you believe may be relevant

Referent's name	**Referral Agency**	**Referral Phone Number**	**Referral Email**	**ROI attached**