Albany County
S.P.O.E.
Single Point of Entry ~ Referral Form
Phone: (518) 447-7777
Fax: (518) 447-2515

****Important Notice****
All referrals containing protected health information must include a signed release of information authorizing disclosure to Albany County.

Last Name:

First Name:

DOB: [ ] M [ ] F

Street Address:

City, Zip Code:

If client is a child, provide name of caregiver and relation to child:

Client's Phone Number and Best Time to Reach:

Race: [ ] Black [ ] White [ ] Hawaiian or Pacific Islander [ ] Asian [ ] Other [ ] Native American/Alaskan
Ethnicity: [ ] Hispanic [ ] Not Hispanic

Referral Source
Name: _____
Agency: _____
Phone: _____

Need Interpreter Services: [ ] Yes [ ] No

Primary Language(s):

Check When to be Seen:
[ ] Same Day/Emergency
[ ] 2-3 Days
[ ] Standard within 1 week

PLEASE COMPLETE THIS SCREENING:

Do you have health insurance:
[ ] yes [ ] no If yes, what kind:_____
Insurance ID Number: _____

Do you have a doctor?
[ ] yes [ ] no If yes, who/where? _____
Phone: _____

Have you had a well woman visit within the last year?
[ ] yes [ ] no
Have you had a regular dental visit in the last year? [ ] yes [ ] no
Do you have problems in your mouth? [ ] yes [ ] no
Describe: _____

PREGNANT? [ ] yes [ ] no Due Date:_____
Prenatal Care: [ ] yes [ ] no
Date of 1st prenatal visit: _____
Delivery Date: _____
Postpartum Appt Date: _____

Have you had a baby born before 37 weeks? [ ]yes [ ]no
Have you had a baby weighing less than 5lbs 8ozs? [ ]yes [ ]no
Are you planning on having more children? [ ]yes [ ]no

DOB of youngest child: _____
Ages of children in the home (or write NONE):
_____

Do you feel safe from violence at home? [ ] yes [ ] no. **If no, call/offer the Equinox 24 Hour Hotline at (518) 432-7865.**

REASONS FOR REFERRAL (CHECK ALL THAT APPLY)

Health Needs:
[ ] Asthma
[ ] Birth Control/Family Planning
[ ] Birth Support (Midwife, Doula, Info)
[ ] Breastfeeding Information/Supports
[ ] Counseling/Mental Health Services
[ ] Dental
[ ] Diabetes
[ ] Diagnosed Medical Condition
[ ] Health Insurance Enrollment
[ ] Healthy Weight/Exercise/ Nutrition
[ ] Heart Disease/High Blood Pressure
[ ] Immunizations
[ ] Lead Evaluation
[ ] Prenatal/ Newborn Nursing Services
[ ] Quit Smoking
[ ] Safe Sex Education (condoms/STI/HIV)
[ ] Substance/Alcohol Use

Social Needs:
[ ] Bereavement/Grief
[ ] Child Care Assistance
[ ] Clothing Assistance/Infant Supplies Referral
[ ]Communication Concerns (Child)
[ ] Domestic Violence Referral
[ ] DSS– PA/TA-- HEAP (circle as needed)
[ ] ESL/HSE/GED etc
[ ] Food Pantry Referral
[ ] Homeless/Shelter Referral
[ ] Housing Assistance Referral
[ ] Parenting Education
[ ] Physical Development Concerns (Child)
[ ] Prenatal Education
[ ] Social/Emotional Concerns
[ ] WIC Referral

Additional Notes:

Early Intervention ~ Healthy Families

Maternal Child Health Nursing ~ WILLOW Community Health Workers

Initials and Date entered into PP

Date Assigned:
Workers Initials:
Supervisors Initials