



Public Health
Prevent. Promote. Protect.

Tuscarawas County Health Department

Tuscarawas County Health Department Programs for Families Referral Form

REFERRED PERSON			
Parent name		DOB	
Preferred language	[] English [] Spanish [] Other (please specify):		
Is client a U.S. citizen or have a qualified exemption? *	[] Yes [] No <i>*Please do NOT provide SS# on this form</i>		
Due date/ children ages			
Phone		Email	
Why are you referring this person? (check all that apply)	<input type="checkbox"/> Cribs for Kids (Criбетtes) <input type="checkbox"/> Ohio Buckles Buckeyes (Car Seats) <input type="checkbox"/> Car Seat Safety Inspection <input type="checkbox"/> Safe Beginnings *Client must be able to provide a SS #* <input type="checkbox"/> Project DAWN (Naloxone/ Narcan) in-person or mail order <input type="checkbox"/> Nicotine Cessation Referral (Ohio Tobacco Quitline) <input type="checkbox"/> Women, Infant, and Children (WIC) *Please attach ROI. <input type="checkbox"/> Immunizations <input type="checkbox"/> Children with Medical Handicaps (CMH)		
REFERRED BY			
Agency name			
Your name		Phone	
Email		Date	
PLEASE RETURN COMPLETED FORM IN PERSON OR VIA EMAIL or FAX			
Email	healthed@tchdnow.org	Fax	330-364-8946
TCHD STAFF USE ONLY			
Date received		Staff	
Contact attempts	1.	2.	3. Lost to follow-up

Thank you for your referral!

There will be three attempts made to reach the individual. Once there have been three unsuccessful attempts, they will be marked as lost to follow-up; however, they are always welcome to call.