Bethlehem Health Bureau
Fax completed form to: 610-865-7326
Questions (610) 865-7083

Partners For A Healthy Baby
Referral/Consent Form

I _____ give my ☐ **verbal** ☐ **written** permission for the
(name of client)
Bethlehem Health Bureau to conduct home visits using the curriculum ***Partners for a Healthy Baby***. Monthly scheduled visits will take place in my home or at a community location by a BHB nurse or bilingual community health specialist from the Bethlehem Health Bureau. I will receive educational materials, and needed supplies. Bethlehem Health Bureau staff may refer me to other BHB services or community agencies as discussed. I give permission for my information to be shared with the appropriate agencies/providers and with the Bethlehem Health Bureau.

Referring Agency/individual:_____

Contact Person: _____Phone: _____

Client/self gives permission for BHB staff to: ___ **call or ___text*** within one week at the number listed below to set up an appointment for the visit. *BHB is not responsible for data charges**

Due date: _____or Child's DOB:_____

Mother: ☐ Black/African American ☐ White ☐ Asian **Hispanic/Latino:** ☐ Yes ☐ No

Infant/Child: ☐ Black/African American ☐ White ☐ Asian **Hispanic/Latino:** ☐ Yes ☐ No

_____ 1st Language Spanish ☐ Other _____
(Print client name)

_____ _____
(signature of client) (date)

_____Bethlehem, PA 1801____
Address of Client

_____ **MUST have 2 #'s** _____
Phone # Alternate Phone #

Date of Referral: _____/_____/_____ _____ _____/____/_____
(WITNESS signature) (date)

Comment_____

_____

01/17 SM