Wee Care
funded by DSHS

PREGNANT/POSTPARTUM INTERVENTION (PPI) PROGRAM REFERRAL FORM

Client Information: **Date:** ___________________________

Name: _______________________________ DOB: ____________ Race/Ethnicity: __________

Phone: _________________________________ Alt. Phone: ___________________________

Address: ____

City: _____________________ State: _____ Zip: _________ County: ____________________

Referring Agency Name: ____

Staff name/position: ____

Address: ____

Office Phone: _____________________________ Alt. Phone: __________________________

Email: ____

Referred to: _LifeSteps **"Wee Care"** Program_ Reason for referral: ____________________________

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Client is (check ✔): ____ **Pregnant** (How many weeks?) ____ **Postpartum** Youngest child's DOB _______

Has client had current or past involvement with DFPS? ____ Yes _____ No

Consent to share information:

I, ___________________________________ agree to allow ___________________________________
(Print name) *(Name of referring agency)*
to **share AND receive** pertinent information regarding my referral to LifeSteps for services.

_____________________________________ _____________________________________
Client Signature *Date Signed*

_____________________________________ _____________________________________
Referring Staff Signature *Date Signed*

For Office Use:

Notes: ____

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Fax to: 512-869-1667 | EMAIL to: weecare@lifestepscouncil.org

(DFPS users must add 1+1+512-869-1667 to fax to LifeSteps)