Bright Start
A program of
CHILDREN'S HOME SOCIETY
In partnership with the South Dakota Department of Health

4402 E. 3rd St.
Sioux Falls, SD 57103
(605) 274-0233
FAX: (605) 274-0235

REFERRAL INTAKE FORM

Date: ____________

Individual Referred

Name: ______________________________ DOB: ___________________ Due Date: _______________

Address: ____

____

Phone Number: (   ) ____

Number of children and ages: ____

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Primary Language: _________________________ Current Interpreter: ___________________________

These are some of the reasons I think the above person may benefit from Bright Start:

□ Teen Parent

□ Single Parent

□ Unemployment/low income

□ History or current depression

□ Late or No Prenatal Care/Poor Compliance

□ History or current substance abuse

□ History or current abuse

□ Limited resources/support

Please explain the situation:

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____

Individual Referring

Name: ___________________ Agency: ______________________ Phone number: (   ) __________

Nurse Assigned: ____ Date: _________________

1st contact date___________   2nd contact date___________   disposition date___________