



Stepping Stones
Intensive Home Visiting Program
REFERRAL FORM



(Please complete all known fields)

Date of Referral _____ Referral Source _____

Teens Name _____ Account Number (if known) _____

Date of Birth _____ Age _____

Telephone Number (H) _____ (C) _____ (other) _____

Address _____

Lives with _____

School Name & Grade _____

Medicaid Status _____

OBGYN Provider _____

Weeks Gestation _____ Gravida/Para _____ EDC _____

Other pertinent information _____

FAX or MAIL to:

Cabarrus Health Alliance – Stepping Stones
 300 Mooresville Rd, Kannapolis, NC 28081
 704-920-1000 -- FAX 704-933-3345

(for completion by Stepping Stones staff only)

Date/Type/Response of Contact _____

Enrolled (Y) ____ (N) ____ (if NO Why) _____

First Visit Date _____

Screened By _____