



Family Community Health & Wellness General Referral Form

Public Health
Prevent. Promote. Protect.
Zanesville-Muskingum County

Today's Date: _____

Who is being referred:

1. Name: _____
2. Date of Birth: _____
3. Phone Number: _____
4. Email Address: _____
5. Preferred method of communication: ☐Text ☐Phone Call ☐Email
6. Address: _____
7. Sex: ☐Male ☐Female ☐Prefer not to say
8. Race (Select all that apply):
 - ☐White
 - ☐Black/ African American
 - ☐Native Hawaiian/ Other Pacific Islander
 - ☐Asian
 - ☐American Indian/ Alaskan Native
 - ☐Other
9. Ethnicity: ☐Hispanic ☐Non-Hispanic ☐N/A
10. Please select which area(s) you would like help with:
 - ☐Car Seat
 - ☐Education
 - ☐Employment
 - ☐Food (For family)
 - ☐Food (For child or dependent)
 - ☐Housing
 - ☐Medical Concerns (For you/adult)
 - ☐Medical Concerns (For child or dependent)
 - ☐Pack-N-Play
 - ☐Parenting Program
 - ☐Pregnancy Support
 - ☐Transportation
 - ☐Utilities
 - ☐Vaccinations
 - ☐Other: _____

11. Approximate income: _____

12. Household size: _____

13. Are you currently pregnant? ☐ Yes ☐ No ☐ N/A

14. If you are pregnant, how many weeks gestation? _____

15. Are you on WIC? ☐ Yes ☐ No

16. Are you on Medicaid? ☐ Yes ☐ No

17. Are you currently receiving services from another agency? ☐ Yes ☐ No

18. If so, what services and where?

19. Please explain the situation related to your needs and provide as many helpful details as possible.

Referral Submitted By:

1. Name: _____

2. Agency: ☐ ZMCHD ☐ Other: _____

3. Phone number: _____

4. Email: _____

5. Does the client know of this referral: ☐ Yes ☐ No

Please submit this referral form to referrals@zmchd.org. Additional information for ZMCHD's programs can be found on **ZMCHD.org** or by calling **(740)454-9741 ext.325**