Following Baby Back Home

A home visiting and case management service for families of medically-complex, high-risk infants.

Please fax referral to: 501-526-8740

FBBH email address FBBHInfo@uams.edu Phone 501-526-8715

Referral Date:	Referring Name & Title:
Referring Hospital:	Contact Phone for Referral Source:

Baby Last Name:	Date of Birth:
Baby First Name:	Discharge Date:
Mother's Name:	□Male □Female □Twin □Triplet
Primary Caregiver name(s): □ Mother □ Grandparent □ Father □ Other (specify)	Gestational Age (weeks): Birth Weight (grams):
Secondary Caregiver(s): □ Mother □ Grandparent □ Father □ Other (specify)	Discharge Weight (grams):
Street Address:	Medicaid #: Private Insurance? □Yes □No PCP: PCP Phone:
City/State/Zip:	
Contact Information: Home _____ Cell (s): _____ Email (s): _____ Emergency Contact/phone: _____	Race (check any applicable): □ African American □ American Indian □ Asian □ Caucasian □ Pacific Islander Ethnicity □ Hispanic □ Non-Hispanic Primary Language: _____ □ Need Interpreter

Caregiver informed of Referral to Following Baby Back Home? □ Yes □ No

Primary Diagnosis: □ PTNB	□ Formula □ BF Type Formula:	Referred to: □ HRNB Clinic □ Medical Home Clinic □ Growth & Development Clinic □ Other_____
Other Diagnoses:	Route of Formula: □ PO □ GT □ Other	

Medical Notes: □ Reflux Precautions □ Seizure Precautions □ Suction □ O_2 Monitor □ Tracheotomy □ GT/Feeding Tube □ Apnea Monitor □ Other:	Surgical Procedures:	Family Support Needs: □ Grief/Loss □ Parenting □ Trauma History □ Mental Health Issues □ Financial Stressors □ Substance Abuse □ High Risk Living Situation □ Current DCFS Involvement

FBBH Office Use

Notified referral source:

□ Out of catchment
□ Placed on waiting list
□ Unable to provide services

□ Central □ Northeast
□ Northwest □ River Valley
□ South □ Southwest