

Following Baby Back Home

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

Please email referral to tafougerousse@uams.edu

Phone 501-526-8732

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:		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Twin <input type="checkbox"/> Triplet	
Primary Caregiver name(s): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Other (specify)		Gestational Age (weeks):		
Secondary Caregiver(s): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Other (specify)		Birth Weight (grams):		
Street Address:		Discharge Weight (grams):		
City/State/Zip:		Medicaid #: Private Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Contact Information: Mother: Father: Email(s): Emergency Contact/phone:		PCP: PCP Phone:		
		Race (check any applicable): <input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Pacific Islander		
		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
		Primary Language: <input type="checkbox"/> Need Interpreter		
Caregiver informed of Referral to Following Baby Back Home? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Primary Diagnosis: <input type="checkbox"/> PTNB		<input type="checkbox"/> Formula <input type="checkbox"/> BF Type Formula:		
Other Diagnoses:		Route of Formula: <input type="checkbox"/> PO <input type="checkbox"/> GT <input type="checkbox"/> Other		
Medical Notes: <input type="checkbox"/> Reflux Precautions <input type="checkbox"/> Seizure Precautions <input type="checkbox"/> Suction <input type="checkbox"/> O ₂ Monitor <input type="checkbox"/> Tracheotomy <input type="checkbox"/> GT/Feeding Tube <input type="checkbox"/> Apnea Monitor <input type="checkbox"/> Other:		Surgical Procedures:		
		Family Support Needs: <input type="checkbox"/> Grief/Loss <input type="checkbox"/> Parenting <input type="checkbox"/> Trauma History <input type="checkbox"/> Mental Health Issues <input type="checkbox"/> Financial Stressors <input type="checkbox"/> Substance Abuse <input type="checkbox"/> High Risk Living Situation <input type="checkbox"/> Current DCFS Involvement		
		<table border="1"> <tr> <td style="text-align: center;"> FBBH Office Use <input type="checkbox"/> Out of catchment <input type="checkbox"/> Placed on waiting list <input type="checkbox"/> Unable to provide services <input type="checkbox"/> Central <input type="checkbox"/> Southwest </td> </tr> </table>		FBBH Office Use <input type="checkbox"/> Out of catchment <input type="checkbox"/> Placed on waiting list <input type="checkbox"/> Unable to provide services <input type="checkbox"/> Central <input type="checkbox"/> Southwest
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Approved by and Date: