Albany County
Single Point of Entry (SPOE) ~ Referral Form

Phone: (518) 447-7777 | Fax: (518) 447-2515

****Important Notice****
All referrals containing protected health information must include a signed release of information authorizing disclosure to Albany County.

Last Name:	First Name:	
Address:	City:	Zip Code:
Gender: ☐ F ☐ M / DOB:	If client is a child, please provide name of caregiver and relationship to child:	
Client's Phone Number and Best Time to Reach:		Referral Source: Name: _____ Agency: _____ Phone: _____
Race: ☐ Black ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian ☐ Native American/Alaskan ☐ Other	Ethnicity: ☐ Hispanic ☐ Not Hispanic	

Need Interpreter Services: ☐ Yes ☐ No

Primary Language(s): _____

Check When to be Seen:
☐ Same Day/Emergency ☐ 2-3 Days ☐ Standard within 1 week

PLEASE COMPLETE THIS SCREENING:

Health Insurance: ☐ Yes ☐ No ☐ Unknown

If YES, what kind _____

Insurance ID No. _____

Doctor (Primary or OB/GYN): ☐ Yes ☐ No ☐ Unknown

If YES, Who/Where: _____

Phone Number: _____

Well woman visit within the last year? ☐ Yes ☐ No ☐ Unknown

Regular dental visit in the last year: ☐ Yes ☐ No ☐ Unknown

Dental Concerns? ☐ Yes ☐ No

Describe: _____

Are you Pregnant? ☐ Yes ☐ No If Yes, Due Date: _____

Prenatal Care: ☐ Yes ☐ No

Date of first prenatal visit: _____

Delivery Date: _____ Postpartum Appt. Date: _____

Birth History:

Have you had a baby born before 37 weeks? ☐ Yes ☐ No

Have you had a baby weighing less than 5lbs 8oz? ☐ Yes ☐ No

DOB of youngest child: _____

Ages of children in the home (or write NONE): _____

_____

Have you received a COVID 19 Vaccination? ☐ Yes ☐ No Would you like assistance scheduling one? ☐ Yes ☐ No

REASONS FOR REFERRAL (CHECK ALL THAT APPLY)

Health Needs:

- ☐ Asthma
- ☐ Birth Control/Family Planning
- ☐ Breastfeeding Information/Supports
- ☐ Community Health Workers/Healthy Families
- ☐ Counseling/Mental Health Services
- ☐ Dental
- ☐ Health Coaching
- ☐ Health Insurance Enrollment
- ☐ Healthy Weight/Exercise/ Nutrition
- ☐ Immunizations
- ☐ Lead Evaluation
- ☐ Medical Condition (diagnosed or suspected)
  Specify: _____
- ☐ Prenatal/ Newborn Nursing Services
- ☐ Quit Smoking Information
- ☐ Safe Sex Education (condoms/STI)
- ☐ Substance/Alcohol Use

Social Needs:

- ☐ Bereavement/Grief
- ☐ Child Care Assistance
- ☐ Clothing Assistance/Infant Supplies Referral
- ☐ Communication Concerns (Child)
- ☐ Domestic Violence Referral (concerns about safety)
- ☐ DSS ☐ PA/TA ☐ HEAP (check as needed)
- ☐ ESL/HSE/GED etc
- ☐ Food Pantry Referral
- ☐ Homeless/Shelter Referral
- ☐ Housing Assistance Referral
- ☐ Parenting Education
- ☐ Physical Development Concerns (Child)
- ☐ Prenatal Education
- ☐ Social/Emotional Concerns
- ☐ WIC Referral

Additional Notes:

Early Intervention ~ Maternal Child Health Nursing
Healthy Families ~ WILLOW Community Health Workers

FOR INTERNAL OFFICE USE ONLY

Initials and Date entered into PP _____

Date Assigned: _____

Workers Initials: _____ Supervisors Initials: _____