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): ____
____

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
- ☐ Doula
- ☐ 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:

For internal office use only: Initials and Date entered into PP ____ Date Assigned: ____ Workers Initials: ____ Supervisors Initials: ____