



## Healthy Ties Referral Form

Date of Referral: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Residing County (if known): \_\_\_\_\_

Number of Children in Home: \_\_\_\_\_

Name of Identified Child: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's next Grady appointment: \_\_\_\_\_

Assigned Nurse Practitioner: \_\_\_\_\_

Nurse Contact Number: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

---

**Please fax completed referral to 678.460.0350**

Family Ties, Inc.  
1900 The Exchange Ste 420  
Atlanta, Georgia 30339  
Office: (678) 460-0345 Fax: (678) 460-0350