ST GIANNA PREGNANCY OUTREACH CENTER

BEFORE ASSISTANCE CAN BE PROVIDED

REFERRAL MUST BE COMPLETED AND FAX TO (716) 847-2206

Referral cannot be completed by the parent/guardian; it must be completed by an Agency/Organization/Hospital/Parish

ALL SERVICES PROVIDED BY APPOINTMENT

CHOOSE WHICH LOCATION IS CLOSER TO YOU: We will call you to schedule an appointment

- ☐ Buffalo Areas (*76 Church St., Buffalo*) Monday -Friday 8:30am-4:00pm Phone: (716) 842-BABY (2229)
- ☐ Cheektowaga Area (*921 Cleveland Dr., Cheektowaga*) Wednesdays 8:30am-Noon Phone: (716) 842-2229
- ☐ Cattaraugus Area (*205 W Henley Street, Olean*) By appointment Phone: (716) 842-2229 Buffalo
- ☐ Chautauqua Area (*32 Moore Ave., Fredonia)* Tuesdays 10am-3pm/ Saturdays 10am-Noon Phone: (716) 401-3324
- ☐ Niagara Area (*625 Tronolone St., Niagara Falls*) Wednesdays 1-4pm By appointment Phone #: (716) 282-2351 Ext 5216

Reason for Referral: _____

Parent/Guardian: _____ PHONE:_____ ALT #:_____

Address:_____ Zip Code_____ Mothers DOB:_____

Is there a safe place for the baby to sleep in?: _____

LIST ONLY INFANT/CHILD NEEDING HELP:

Name	M/F	Due Date/DOB	Clothes Size through 4T
1.			
2.			
3.			

Check **ONLY** items needed:

Clothes/Sleepers/Onesies	☐	Blankets	☐
Bottles/pacifier	☐	Bibs	☐
Coat/jacket/sweaters	☐	Wipes	☐

Diapers (initial visit) please indicate size

NB	☐	1	☐	2	☐	3	☐	4	☐
Other:									

Others: _____

If English not spoken, translator must be provided

***Please provide translator's name & phone #** _____

DATE REFFERRED TO OFFICE: _____

AGENCY/ORGANIZATION/HOSP./OTHER: _____ PHONE:_____ EXT_____

NAME OR SOCIAL WORKER/MENTOR/OTHER: _____

Also referred to: _____ / Other Services needed:_____

FOR OFFICE USE ONLY: Appointment _____ **Time:** _____

Date Serviced: _____ **Serviced by:** _____

Picked up by ___ Mother/Father/Guardian ___ Worker/Mentor ___ other (if other) Name _____

Signature of who picked up: _____

REV. 8-26-2020