ST GIANNA PREGNANCY OUTREACH CENTER

BEFORE ASSISTANCE CAN BE PROVIDED

A REFERRAL MUST BE COMPLETED BY AGENCY/HOSPITAL AND FAX TO (716) 847-2206

ALL SERVICES PROVIDED BY APPOINTMENT

CHOOSE A LOCATION CLOSEST TO YOU: **The family will be called to schedule an appointment**

- ☐ Buffalo Area (76 Church St., Buffalo, NY) Mon-Fri 8:30am-4pm Phone: (716) 842-2229
- ☐ Cattaraugus Area (205 W. Henley St., Olean, NY) By Appointment Phone: (716) 373-2569
- ☐ Chautauqua Area (32 Moore Ave., Fredonia, NY) Tues. 10am-3pm/Sat. 10am-Noon Phone: (716) 401-3324
- ☐ Cheektowaga Area (921 Cleveland St., Cheektowaga, NY) Wednesdays 8:30am-Noon Phone: (716) 842-2229
- ☐ Lackawanna Area (780 Ridge Rd., Lackawanna, NY) Thursdays 9:30am-3:30pm Phone: (716) 828-9654
- ☐ Niagara Area (625 Tronolone St., Niagara Falls, NY) Wednesdays 1pm-4pm Phone: (716) 299-7040
- ☐ Wyoming Area (8 Park St., Perry, NY) By appointment Phone: (585) 969-4150

REASON FOR REFERRAL: _____

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

Mothers DOB _____ ***If English not spoken; translator must be provided***

Please provide translator's name & phone # _____

Parent/Guardian Address:_____ Zip Code _____

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

LIST ONLY INFANT/CHILD NEEDING HELP:

NAME	GENDER	DUE DATE/DOB	CLOTHES SIZE (up to 4T)
Child's Name	**M/F**	**Month/Date/Year**	**Indicate ONLY one Size Needed**
1.		/ /	
2.		/ /	
3.		/ /	

Check ONLY items needed:

☐	Clothes/Sleepers/Onesies
☐	Bottles
☐	Blankets ☐ Bibs ☐ Wipes

Diapers (initial visit) please choose **ONLY** one size

NB ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

Other: _____

Others: _____

DATE REFFERRED TO OFFICE: _____ NAME OF SOCIAL WORKER/MENTOR:_____

AGENCY/ORGANIZATION/HOSP: _____ PHONE:_____ EXT_____

FOR OFFICE USE ONLY: **Date Serviced:** _____ **Serviced by:** _____

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

REV. 9-11-2023