S · H · A · S · T · A

HEAD START

CHILD DEVELOPMENT, INC.

"The Future Starts Here"

Please Fax To: (530)_____

Prenatal Visit Verification

Completed by Head Start Staff

Early Head Start Site: _____Home Visitor:_____
Expectant Women's Name:_____ DOB:_____
Expected Due Date: _____
Health Care Provider_____
Phone_____ Fax _____

Completed by Health Care Provider Office

Dear Health Care Provider,

Please indicate the dates you saw the above named woman in your office for prenatal care and whether there were any concerns with her pregnancy at those visits.

Prenatal Visit Dates: _____ _____
_____ _____
_____ _____

- Were there any concerns at these visits? □Yes □No

If yes, what?

_____ _____
Health Care Provider's Signature Date

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