

# Home Visitation Program Referral Form H-705

Attention: City of Milwaukee Health Department Central Intake

Phone: 414/286-8620 Fax: 414/286-5480

<b>Office use only:</b>
Date received: _____
Program Assignment: _____
Aldermanic District: _____

Date: \_\_\_\_\_ Name of Person Completing Referral \_\_\_\_\_

**REASON FOR REFERRAL:**  Pregnant woman  Expectant/Parenting father  Both

**PREGNANT WOMAN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Ethnicity:** (check only one)  Hispanic  Not Hispanic

**Race:** (check all that apply)  American Indian/Alaska Native  Asian  Black  White  Native Hawaiian/Pacific Islander

**Address:** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Alternate Number:** \_\_\_\_\_

**Due date:** \_\_\_\_\_ **First-time Parent?**  Yes  No

**Primary language:** \_\_\_\_\_ **Insurance:**  Medicaid/BadgerCare+  Private  None

**Primary Care Provider:** \_\_\_\_\_

**FATHER:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Ethnicity:** (check only one)  Hispanic  Not Hispanic

**Race:** (check all that apply)  American Indian/Alaska Native  Asian  Black  White  Native Hawaiian/Pacific Islander

**Address:** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Alternate Number:** \_\_\_\_\_

**Primary language:** \_\_\_\_\_ **Insurance:**  Medicaid/BadgerCare+  Private  None

**Primary Care Provider:** \_\_\_\_\_

<b>Office use only:</b>
<b>Pregnant Woman SPHERE#</b>
_____
<b>Father SPHERE#</b>
_____
<b>Child SPHERE#</b>
_____

**CHILD:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Sex:**  Male  Female

**Are any other agencies serving this family?**  Yes  No

If yes, please check all that apply:  WIC  BMCW  Other home visiting program: \_\_\_\_\_  
Program Name

**Please check all that apply:**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Interested in home visiting services | <input type="checkbox"/> Chronic medical condition  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> First-time parent                    | <input type="checkbox"/> Cognitive delay/disability | _____                                 |
| <input type="checkbox"/> Pregnancy within last 12 months      | <input type="checkbox"/> Mental health concerns     | _____                                 |
| <input type="checkbox"/> Inadequate prenatal care             | <input type="checkbox"/> Lack of support system     | _____                                 |
| <input type="checkbox"/> Previous preterm birth               | <input type="checkbox"/> Homeless/housing concerns  | _____                                 |
| <input type="checkbox"/> Previous adverse outcome (SIDS)      | <input type="checkbox"/> AODA concerns              | _____                                 |

**Referred by:**

Agency \_\_\_\_\_

Telephone \_\_\_\_\_ Fax: \_\_\_\_\_

Worker: \_\_\_\_\_

Discussed referral with client:  Yes  No