Email completed form to MCHHVRef@milwaukee.gov or fax it to (414) 286-5480.

City of Milwaukee Health Department

Home Visitation Program Referral Form H-705

Attention: City of Milwaukee Health Department Central Intake
Phone: (414) 286-8620 Fax: (414) 286-5480

Office use only: Date received: _____
Program Assignment: _____
Aldermanic District: _____
Targeted Program: ☐BOMB ☐DAD ☐EFM ☐PNCC

Date: _____ Name of Person Completing Referral _____

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

PREGANANT WOMAN: _____ **DOB:** _____ **SPHERE #:**

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:** _____ **SPHERE #:**

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: _____

CHILD: _____ **DOB:** _____ **SPHERE #:**

Sex: ☐ Male ☐ Female

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

If yes, please check all that apply: ☐ WIC ☐ DMCPS ☐ Other home visiting program: _____
Program Name

Please check all that apply:

☐ Interested in home visiting services
☐ First-time parent
☐ Pregnancy within last 12 months
☐ Inadequate prenatal care
☐ Previous preterm birth
☐ Previous adverse outcome (SIDS)
☐ Chronic medical condition
☐ Cognitive delay/disability
☐ Mental health concerns
☐ Lack of support system
☐ Homeless/housing concerns
☐ AODA concerns
☐ Interested in Doula Services
☐ Other:

Referred by:

Agency _____ Worker _____

Telephone _____ Fax _____ Discussed referral with client: ☐ Yes ☐ No

• **IF PREGNANT, PLEASE ATTACH VERIFICATION STATEMENT** •