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: _____

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: _____

Office use only:

Pregnant Woman SPHERE#

_____

Father SPHERE#

_____

Child SPHERE#

_____

CHILD: _____

DOB: _____ **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** •