City of Milwaukee Health Department

Home Visitation Program Referral Form

Attention: City of Milwaukee Health Department Central Intake

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

For office use only:

Date received: _____

Program Assignment: _____

Date Assigned: _____

SPHERE #: _____

Date: _____ Name of Person Taking Referral _____

Client's Name: _____ DOB: _____ Age: _____
Last First MI mm/dd/yyyy

Infant's Name: _____ DOB: _____
(if applicable) Last First MI mm/dd/yyyy

Street Address: _____ ZIP _____

Primary Telephone: _____ **Cellular:** _____ **Alternate Telephone** _____

Alternate Contact Name & Number _____

Primary Language:

Type of Insurance:

Primary Care Info:

Referred by:

Agency _____

Worker _____

Telephone _____ Fax: _____

Discussed referral with client: ☐ Yes ☐ No

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

If yes, please check all that apply:

☐ WIC ☐ BMCW ☐ Social service agency

☐ Other home visiting program

☐ Other _____

Reason for Referral:

☐ High-risk pregnancy ☐ High-risk infant ☐ Other

EDD _____ Is this a first pregnancy? ☐ Yes ☐ No

Please check all that apply:

- ☐ Pregnancy within last 12 months
- ☐ Inadequate prenatal care
- ☐ Previous preterm birth
- ☐ AODA concerns
- ☐ Mental health concerns
- ☐ Cognitive delay / disability
- ☐ Lack of a support system
- ☐ Interested in home visiting services
- ☐ STDs
- ☐ UTI
- ☐ Chronic medical condition
- ☐ Homeless / housing concerns
- ☐ Previous adverse outcome (SIDS)
- ☐ Birth weight less than 2000 grams (4 lbs. 6 oz.)
- ☐ Infant less than 35 weeks' gestation
- ☐ Other: _____

If pregnant, please attach verification statement.