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

Date: _____ Name of Person Taking Referral _____

Client's Name: _____ DOB: _____
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:

Primary Care Info:

Type of Insurance:

Referred by:

Agency _____

Worker _____

Telephone _____

Other agencies active with family:

Reason for Referral:

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

EDD _____

Is this a first pregnancy? ☐ Yes ☐ No

Reason for referral: _____

If pregnant, please attach verification statement.

FOR OFFICE USE ONLY:

Date received by MHD: _____ *Program Assignment:* _____ *Date:* _____