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:

Type of Insurance:

Primary Care Info:

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:* ______________