Racine County Home Visitation Network

A Community Project to Promote Healthy Babies and Families

PRENATAL AND POSTPARTUM REFERRAL

Date: ____/____/____ ☐ Prenatal Referral ☐ Postpartum Referral

Name of Referral Agency/Individual: _____ Phone:_____

Pregnancy Verification Signature: _____ + Pregnancy Test Date: ____/____/____

	MOTHER			INFANT (if postpartum)			
FIRST NAME							
LAST NAME							
DOB/Age	DOB:____/____/____ Age: _____			____/____/____			
ADDRESS							
	Street	City		State	Zip		
MUNICIPALITY	☐ Racine ☐ Caledonia ☐ Mt. Pleasant ☐ Sturtevant ☐ Elmwood Park ☐ Wind Point ☐ North Bay ☐ West of I-94_____						
Email Address							
CLIENT PHONE	(Home) __ __ __ - __ __ __ - __ __ __ __ (Cell or other) __ __ __ - __ __ __ - __ __ __ __						
RACE	☐ White ☐ Black ☐ Asian ☐ Asian Indian ☐ Other			☐ White ☐ Black ☐ Asian ☐ Asian Indian ☐ Other			
ETHNICITY	☐ Hispanic ☐ Non-Hispanic			☐ Hispanic ☐ Non-Hispanic			
HEALTH INSURANCE	☐ Yes ☐ No ☐ Underinsured			☐ Yes ☐ No ☐ Underinsured			
INSURANCE TYPE	☐ Medicaid ☐ Badgercare ☐ Other			☐ Medicaid ☐ Badgercare ☐ Other			
PROVIDER/MD							
PROVIDER PHONE #							
EMPLOYED	☐ Yes ☐ No ☐ Underemployed						
HIGH SCHOOL (if applicable)							
DUE DATE (EDC)	____/____/____ **1st PRENATAL VISIT**____/____/____						
GRAVIDA		**PARA**		**Birth Wt.**		**Birth Length**	

OTHER RISK FACTORS			
Limited English	☐ Yes ☐ No	Low Income	☐ Yes ☐ No
Less than 12th Grade Education	☐ Yes ☐ No	At Risk for Poor Birth Outcomes	☐ Yes ☐ No
Marital Status = Single	☐ Yes ☐ No	At Risk for Child Welfare Involvement	☐ Yes ☐ No
BMI <19.8 or >26.0	☐ Yes ☐ No	Current/Past Child Welfare Involvement	☐ Yes ☐ No
WIC	☐ Yes ☐ No	Other Children removed from the Home	☐ Yes ☐ No
Previous Infant Death, Pre-term Birth, LBW, loss @20+ wks.	☐ Yes ☐ No	Alcohol and/or Other Drug Use or History of Use in Family	☐ Yes ☐ No
Pregnancy Interval < 12 months	☐ Yes ☐ No		
STDS and/or UTI	☐ Yes ☐ No	Tobacco Users in the Home	☐ Yes ☐ No
Hypertension, Diabetes, Asthma, Seizures and/or Epilepsy	☐ Yes ☐ No	Children in Home at Risk For or With Low Academic Achievement	☐ Yes ☐ No
Other Medical Condition	☐ Yes ☐ No		
Dental Issues	☐ Yes ☐ No	Children at Home with Delays/Disabilities	☐ Yes ☐ No
Current Tobacco Use	☐ Yes ☐ No	Family member is/was in Armed Forces	☐ Yes ☐ No
Alcohol and/or Other Drug Use or History of Use	☐ Yes ☐ No	History of Child Abuse/Neglect as a Child	☐ Yes ☐ No
Abuse by partner or someone close	☐ Yes ☐ No	History of Victimization by Intimate Partners	☐ Yes ☐ No
Nutrition/Hunger Problems	☐ Yes ☐ No		
Housing Problems in the Past Three Months	☐ Yes ☐ No	Lack of Social Supports or Social Isolation	☐ Yes ☐ No
Transportation and/or Childcare Issues	☐ Yes ☐ No	Other:	☐ Yes ☐ No
History of Mental Health Concerns	☐ Yes ☐ No	_____	
Symptoms of Depression	☐ Yes ☐ No	_____	
High Stress Level	☐ Yes ☐ No	_____	

FAX TO: 262-633-2619

Racine County Home Visiting Network
2405 Northwestern Ave, Ste. 205, Racine, WI 53404
Phone: 262-633-3591 Email: RCHVN.Referrals@cssw.org

For Office Use Only:

Date Rec'd: _____ Intermediary Agency:_____
Accepted Services: **Y / N** WFHC Medical Home: **Y / N**
If no, reason: _____

12-4-12