

CENTRAL OREGON TRI-COUNTY PUBLIC HEALTH SERVICES

REFERRAL FOR MATERNAL AND CHILD HEALTH HOME VISITING SERVICES

TODAY'S DATE	REFERRED BY <i>(your name, organization & phone number)</i>	YOUR FAX NUMBER
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PREGNANCY

CLIENT'S NAME <i>(as it appears on OHP card)</i>	
DOB	DUE DATE _____ UNDER 28 WKS? <input type="checkbox"/> Y <input type="checkbox"/> N
# PREGNANCIES (INCLUDING THIS ONE) _____	
# CHILDREN _____	
Is client Medicaid / OHP / CAWEM eligible? <input type="checkbox"/> Y <input type="checkbox"/> N	
Is client a first-time mother? <input type="checkbox"/> Y <input type="checkbox"/> N	
CLIENT'S DOCTOR	

CHILD

CLIENT'S NAME <i>(as it appears on OHP card)</i>	
DOB	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PARENT / GUARDIAN'S NAME	
Is child Medicaid / OHP eligible? <input type="checkbox"/> Y <input type="checkbox"/> N	
Is mother/father a first-time parent? <input type="checkbox"/> Y <input type="checkbox"/> N	
CHILD'S DOCTOR	

ADDRESS	CITY	OREGON	ZIP
PHONE(S) #	VOICE MSG. OK? <input type="checkbox"/> Y <input type="checkbox"/> N TEXT MSG. OK? <input type="checkbox"/> Y <input type="checkbox"/> N	CLIENT/ GUARDIAN CONSENTS TO RECEIVE CONTACT FROM HOME VISITING PROGRAMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

REASON FOR REFERRAL *(Please include any instructions e.g. Interpreter needed, client's situation, best days/times to call, only speak to...)*

***** Optional Client release** *(Deschutes County only):* I give permission to Deschutes County to share the information above with Healthy Families Oregon (HFO) if I do not qualify for Deschutes Home Visiting Services services* * *

Client or Guardian Signature _____ Date _____



CROOK COUNTY

375 NW Beaver St. Ste. 100,
Prineville, OR 97754 (541) 447-5165

FAX (541) 447-3093



DESCHUTES COUNTY

2577 NE Courtney Drive
Bend, OR 97701 (541) 322-7499

FAX (541) 322-7463



JEFFERSON COUNTY

715 SW 4th St. Suite C,
Madras, OR 97741 (541) 475-4456

FAX (541) 475-0132

COUNTY USE - REFERRAL FOLLOW-UP County point of contact: _____

This client was referred to the following home visiting programs:

- Babies First
 CaCoon
 Early Head Start
 Healthy Families Oregon
 Maternity Case Management
 Nurse Family Partnership
 Other Home Visiting _____

The following is the outcome of your referral:

- Accepted** home visiting services, their nurse case manager is: _____
 Declined enrollment in home visiting services.
 Unable to visit due to caseload capacity limits at this time.
 Family could not be reached after multiple contact attempts by staff.
 Referred / linked to: _____

Notes