# CENTRAL OREGON TRI-COUNTY PUBLIC HEALTH SERVICES

## REFERRAL FOR MATERNAL CHILD HEALTH HOME VISITING SERVICES

| TODAY'S DATE | REFERRED BY (*your name, organization & phone number*) | YOUR FAX NUMBER |
|---|---|---|
| | | |

### PREGNANCY

| CLIENT'S NAME *(as it appears on OHP card)* | |
|---|---|
| DOB | DUE DATE_____<br>UNDER 28 WKS? ☐ Y ☐ N |
| # PREGNANCIES (INCLUDING THIS ONE) _____<br># CHILDREN _____ | |
| Is client Medicaid / OHP / CAWEM eligible? ☐ Y ☐ N | |
| Is client a first-time mother? ☐ Y ☐ N | |
| CLIENT'S DOCTOR | |

### CHILD

| CLIENT'S NAME *(as it appears on OHP card)* | |
|---|---|
| DOB | ☐ MALE<br>☐ FEMALE |
| PARENT / GUARDIAN'S NAME | |
| Is child Medicaid / OHP eligible? ☐ Y ☐ N | |
| Is mother/father a first-time parent? ☐ Y ☐ N | |
| CHILD'S DOCTOR | |

| ADDRESS | | CITY | OREGON | ZIP |
|---|---|---|---|---|
| PHONE # | VOICE MSG. OK? ☐ Y ☐ N<br>TEXT MSG. OK? ☐ Y ☐ N | CLIENT/GUARDIAN CONSENTS TO RECEIVE CONTACT FROM PUBLIC HEALTH HOME VISITING PROGRAMS? ☐ Y ☐ N | | |

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

*****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*******

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**

**This client qualifies for the following home visiting programs:** ☐ None Triage Nurse: _____

☐ Babies First ☐ CaCoon ☐ Healthy Families Oregon

☐ Maternity Case Management ☐ Nurse Family Partnership

**The following is the outcome of your referral:**

- ☐ **Accepted** home visiting services, their nurse case manager is: _____
- ☐ **Declined** enrollment in Public Health Nurse Home visiting program.
- ☐ **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 _____