

**MONROE COUNTY DEPARTMENT OF PUBLIC HEALTH  
P.A.T. PERINATAL HEALTH  
NURSE-FAMILY PARTNERSHIP  
Referral Form  
Phone: (585) 753-5437, Fax: (585) 753-5272**

MCDPH Office Use Only  SPOE Staff Initials:  _____
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**DEMOGRAPHIC INFORMATION:**

Date of Birth: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Marital Status:  Married  Single  Other: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Bldg #: \_\_\_\_\_

City:  Rochester  Other: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_  Home  Cell  Pager

Alternate Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_  Home  Cell  Pager

Pets in the Home:  None  Dogs  Cats  Birds  Other: \_\_\_\_\_

Race:  Black  White  Asian  American Indian/Alaskan Native  Native Hawaiian/Pacific Islander  Other

Hispanic:  Yes  No

Primary Language:  English  Spanish  Other: \_\_\_\_\_ If Spanish/Other, Speaks English:  Yes  No

Special Communication Needs:  Needs Interpreter  Hearing Impaired  Sight Impaired  Other: \_\_\_\_\_

Employment Status:  Disabled  Full Time  Part Time  Student  Unemployed

Name of School (if enrolled): \_\_\_\_\_

What is the best time to visit? \_\_\_\_\_

**HOUSEHOLD MEMBERS:**

Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____

**INSURANCE INFORMATION:**

No Medical Insurance

<u>Insurance Type</u>	<u>Insurance Number</u>	<u>Insurance Type</u>	<u>Insurance Number</u>
<input type="checkbox"/> Blue Choice Option	_____	<input type="checkbox"/> Medicare	_____
<input type="checkbox"/> Child Health Plus	_____	<input type="checkbox"/> MVP Health Care	_____
<input type="checkbox"/> Excellus BC/BS	_____	<input type="checkbox"/> MVP Option	_____
<input type="checkbox"/> Family Health Plus	_____	<input type="checkbox"/> MVP Option Child	_____
<input type="checkbox"/> Fidelis	_____	<input type="checkbox"/> MVP Option Family	_____
<input type="checkbox"/> Healthy New York	_____	<input type="checkbox"/> Presumptive Eligibility	_____
<input type="checkbox"/> Medicaid (CIN)	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Medicaid Pending	_____	<input type="checkbox"/> Other: _____	_____

**HEALTH CARE PROVIDER:**

Name of Office/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

OB/GYN Provider: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Bldg/Suite: \_\_\_\_\_

City:  Rochester  Other: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**REFERRAL DETAILS:**

Date of Referral: \_\_\_\_\_ Client's EDD (due date): \_\_\_\_\_ Gravida: \_\_\_\_ Para: \_\_\_\_

Person Requesting Services: \_\_\_\_\_ Title: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Reason for Referral:**

- Prenatal/Parenting Education     Needs Medical Insurance     Missing OB Appointments     Needs WIC
- Other: \_\_\_\_\_

**Please Check if the Following:**

- |                     |  |                                       |
|---------------------|--|---------------------------------------|
| Domestic Violence   | <input type="checkbox"/> Current History | <input type="checkbox"/> Past History |
| Chemical Dependency | <input type="checkbox"/> Current History | <input type="checkbox"/> Past History |
| Mental Health       | <input type="checkbox"/> Current History | <input type="checkbox"/> Past History |

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Services Currently Involved With the Client (ie: Babylove, visiting nurse, mental health, chemical dependency, CPS, etc.):**

<i>Contact Name &amp; Agency</i>	<i>Phone</i>	<i>Address</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any safety concerns for the community health worker/parent educator or nurse?     No     Yes

If yes, explain: \_\_\_\_\_

**CONSENT:**

**Consent has been given to the referral source by the client for the following:**

- **Referral to the Perinatal Home Visiting Program and/or Nurse Family Partnership.**
- **Sharing of information contained in this referral.**
- **Entering information for this referral into the Peer Place Network (electronic database).**

**Yes**

**No (referral cannot be accepted by PHVP/NFP without this consent).**