**\*Check all that apply\***

[ ]  **Prenatal Care Coordination:** Any pregnant women with risk factors marked below
 (PNCC) Public Health Nurse home visit until infant is 2 months old

[ ]  **Maternal Child Health:** Any postpartum woman with risk factors marked below

 (MCH) Public Health Nurse home visit

**Today’s Date:**        **Client Informed of Referral:**  [ ]  Yes [ ]  No **OK to text:** [ ]  Yes [ ]  No

**Language:** [ ]  English [ ]  Spanish [ ]  Other

**Low Income:** [ ]  BadgerCare/Medicaid [ ]  Enrolled in WIC [ ]  Other \_\_\_\_\_\_\_\_\_ *Insurance Number*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Last** | **First** | **DOB** | **EDD** |
| **MOTHER** |        |        |        |   |
| **NEWBORN 1** |        |        |        | [ ]  **M** [ ]  **F** |
| **NEWBORN 2** |        |        |        | [ ]  **M** [ ]  **F** |

**Address:**       **Apt. #:**       **City:**       **Zip:**

**Phone Number:**       \_\_\_ **Alternate Contact Number:**        **County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Perinatal Risk Factors and Postpartum Conditions**

[ ]  History of pre-term labor or low birth weight baby

[ ]  Underweight or [ ]  Overweight

[ ]  Depression/History of Depression (including prenatal/postpartum) or other mental health problems

[ ]  Diabetes/Pre-diabetes: current or past gestational diabetes

[ ]  Hypertension: current or past pregnancy-induced hypertensive disorder (including pre-eclampsia)

[ ]  Other medical condition(s):

[ ]  Oral health problems

[ ]  Current or history of alcohol OR [ ]  drug abuse

[ ]  Current or recent history of *tobacco/marijuana smoking*

[ ]  History of miscarriage and/or fetal/neonatal death

[ ]  Breastfeeding concerns

**General Risk Factors**

[ ]  Cognitive or sensory limitations that may impact pregnancy

[ ]  Not a High School graduate

[ ]  Single/Poor support system

[ ]  Unplanned pregnancy

[ ]  Later, sporadic, or no prenatal care

[ ]  Intimate Partner Violence

[ ]  Housing, transportation, and/or food access concerns

**Current Problems with Infant**

[ ]  Infant with significant feeding problems

[ ]  Medical condition(s):

[ ]  Apgar Score: \_\_\_\_\_\_\_

[ ]  Birth Wt: \_\_     \_\_ Discharge Wt: \_\_     \_\_

[ ]  Other:

**Comments:**

**Person/Agency Referring:**       **Phone:**

Response Requested: [ ]  Yes [ ]  No

Send this form to the **Columbia County Division of Health @** **FAX: 608-742-9700 /** Phone: 608-742-9227