**\*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