Multnomah County Health Department

Prenatal, Maternal & Child Home-Visiting Program
Early Childhood Services (ECS)
REFERRAL FORM

Public Health
Prevent. Promote. Protect.

(*Note: with the exception of African American prenatal, private insured are not eligible)

Fax: 503-988-5612 **Phone: 503-988-3520** **Referral #:**_____

SECTION 1: REFERRED BY

Referring Provider Name:_____ Agency:_____

Phone:_____ Fax:_____ Today's Date: ___/___/___

SECTION 2: CLIENT

Name: _____
MRN: _____
DOB: _____/_____/_____ Sex: M ____ F____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race (check all that apply): ☐ Alaskan Native ☐ American Ind. ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White

☐ Needs Interpreter/Language:_____

Street Address:_____ City:_____ Zip:_____

Mailing Address, if different:_____ ☐ OK to mail

Home phone #:_____ ☐ OK to call Cell phone #_____ ☐ OK to call ☐ OK to text

SECTION 3: PRENATAL INFORMATION

Client's Estimated Due Date: _____/_____/_____
Previous Pregnancies:_____ # Live Births:_____
Insurance: ☐ OHP ☐ CAWEM Plus ☐ Private w/OHP ☐ None
Medicaid ID#:_____
Priority is given to clients in early pregnancy and with OHP.

SECTION 3A: PRENATAL ELIGIBILITY CRITERIA

☐ Teen <20 years old
☐ First time parent
☐ Black/African American

SECTION 4: BREASTFEEDING/LACTATION

☐ Breastfeeding issues/lactation consultation **(Multnomah County Health Department Clients Only)**
Area of concern: _____
_____

SECTION 5: REASON FOR REFERRAL (Please use this space to explain risk factors and reason for referral.)

SECTION 6: INTERNAL USE ONLY

☐ Multiple Birth ☐ WIC client ☐ ICS client ☐ Previous ECS Client ☐ Pended: Date timing out of NFP _____/_____/_____