Maternal Child and Family Health Home Visiting Program
REFERRAL FORM

Multnomah County
Health Department

Client must live in Multnomah County

Fax: 503-988-5612 **Phone: 503-988-3520** **Email/Scan to: ecs.referrals@multco.us**

SECTION 1: REFERRED BY

Referring Provider Name:_____ Agency:_____

Phone:_____ Email:_____ 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: ELIGIBILITY CRITERIA (choose all that apply)

☐ Pregnant
☐ Pregnant, African American

☐ Postpartum or Baby up to 2 months old
☐ Insurance: ☐ OHP ☐ Private ☐ None

Clients Estimated Due Date: ___ /___ /_____
First Time Parent: ☐ Yes ☐ No
Previous Pregnancies: _____ # Live Births: _____
Baby DOB: ___ /___ /_____
Medicaid ID #: _____

SECTION 4: REASON FOR REFERRAL (Please use this space to explain risk factors and reason for referral.)