Macomb County Health Department

Home Visiting Referral

Caregiver/Client Name:_____ **DOB:**_____

Address:_____ **Apt #**_____ **City:**_____ **Zip:**_____

Phone #:_____ **Language:**_____

EDC:_____ **Has the client had a previous live birth?** ☐ Yes ☐ No

Type of Insurance:_____ **OB/Clinic Name:**_____

Infant/Child's Name:_____ **DOB:**_____ **Sex:** ☐ M ☐ F

Weeks Gestation:_____ **Birth Weight:**_____ **Length:** _____

Hospital:_____ ☐ Vaginal ☐ C-Section

If Multiple:

Infant/Child's Name:_____ Sex: ☐ M ☐ F

Birth Weight:_____ Length: _____

Reason for Referral:

Referred by:_____ **Agency:**_____

Date:_____ **Phone #:**_____ **Family Aware of Referral?** ☐ Yes ☐ No

Fax Completed Referral to 586-465-8455

Call 586-465-8429 or email homevisiting@macombgov.org if you have any questions

Please check which program you are referring for:

☐ **Nurse-Family Partnership**- evidenced-based home visiting program for income eligible people who are less than 28 weeks pregnant with their first baby

☐ **Maternal Infant Health Program**- evidenced-based home visiting program for Medicaid eligible pregnant people, infants, and their families

☐ **Public Health Nursing**- home visiting program for pregnant women, families with infants and young child that has no income or insurance requirements

☐ **Other/Program of Best Fit**- we will contact the family to see which program best meets their needs

For Office Use Only:

Caregiver M&M#_____ Infant/Child M&M#_____ FF#_____ RN Assigned:_____