Maternal-Child Home Visitation Programs Referral Form

Mother's Name: ______________________________ Mother 's DOB: ____/_____/_____
Nombre de Mama: *Fecha de Nacimiento de la Madre:*

Father's Name:______________________________ Father's DOB: ____/_____/_____
Nombre de Papa: *Fecha de Nacimiento del Padre:*

Child's Name: ______________________________ Child's DOB: ____/_____/_______
Nombre de Niño: *Fecha de Nacimiento del Niño:*

EDC (Due Date): _____/______/______ Cell Phone: (______) ___________________
Fecha Aproximada del Parto: *Numero de celular:*

Address: ______________________________ Other Phone:__________________
Domicilio: Street/Calle *Otro number de telefono*

________________ ________________ Email: ______________________________
City/*Ciudad* Zip Code */Código Postal* *Correo Electrónico:*

Language(s): □English □ Limited English □Spanish □Other:______ Can we text you?____________________
Idioma(s): *Inglés* *Inglés Limitado* *Español* *Otro:* *Podemos enviar un texto?*

Check all that apply *Marque todos que aplican*:

- □ Private Insurance *Aseguranza Privada*
- □ Medical Card *Tarjeta Medica*
- □ Regular Doctor *Doctor regular*
- □ Early Intervention *Intervencion Temprana*
- □ Reliable Transportation *Transportacion seguro*
- □ Tobacco use in the home *Uso de tabaco en la casa*
- □ Homeless Sin casa
- □ Temporarily sharing home with others *Comparto casa con otros temporalmente*
- □ Stable housing *casa estable*
- □ WIC
- □ SNAP
- □ FCM
- □ SSI or SSD
- □ TANF
- □ Single *Soltero/a*
- □ Married *Casado/a*

Education *Educacion:*
Completed *Terminado*: □ High School □ Some College □ Associate Degree □ Bachelor's Degree □ GED
Currently Enrolled in *Estoy en*: □ Middle School □ High School □ GED □ College

Other Children *Otros hijos:* **If more than 2 children please continue on back *Si tienes mas que 2 hijos por favor continua en el otro lado***

Name *Nombre*:___________________ DOB: ____________ Name *Nombre*:___________________________ DOB: ____________

I am interested in having a home visitor. I give permission for information from today's assessment to be shared with Kane County Home Visitation Programs/Collaborative through Visit Tracker, the Illinois electronic referral system. I understand that this information will be shared only to enable me to have contact with a home visitor, and that all information will be kept confidential by the home visit collaborative/programs and Visit Tracker.
Estoy interesada en recibir una visita a domicilio. Doy permiso para que la información de la evaluación del día de hoy se comparta con "Kane County Home Visiation/Collaborative a través del Visit Tracker, el sistema electrónico de remisiones de Illinois." Entiendo que esta información se compartirá solamente para permitirme tener contacto con una persona del programa que me visite en casa y que toda la información se mantendrá confidencial por parte del programa de visitas a domicilio y el Visit Tracker.

Client Signature/ ______________________________________ Date/ ________________
Firma del cliente *Fecha*

Referred by: ______________________________
Name
____
Agency

Please Check One/*Favor de Marcar Una*:
- ☐ First Time Mother/*Madre Primeriza*
- ☐ Second Time Mother/*Mama por Segunda Vez*
- ☐ Third Time or More Mother/*Mama por Tercera vez o más*

For MIECHV Agency Only: **Told of all HV programs?** ☐**Yes** ☐**No** **Keeper** ☐**Yes** ☐**No**

Please fax completed referral forms to the Kane County Health Department at **(630) 897-4845**

Maternal-Child Home Visitation Programs **Referral Form**

Client Name:____
(Last) (First) (MI)

Please answer the following questions:

1. Race/Ethnicity:
   Hispanic/Latino □ YES □ NO
   □ American Indian or Alaska Native
   □ Asian
   □ Black or African American
   □ Caucasian
   □ Native Hawiian or Pacific Islander
   □ More than one race
2. Does the family have current of former military members □Yes □No
3. Any developmental delays in the home: □Yes □No
4. Any concerns about child's development (please describe)?
   ____
5. Mental Health Issues (please describe):
   ____
6. History of Post-Partum Depression: □Yes □No
7. Late or no prenatal care/lack of compliance: □Yes □No
8. History of Miscarriage/fetal death: □Yes □No
9. Abortion sought/attempted: □Yes □No
10. Adoption sought/attempted: □Yes □No
11. Father of Baby: □ Very Involved □ Somewhat Involved □ Not Involved □ Gang Involvement □Unemployed
12. Crime Involvement of client, partner or family member: □Yes □No
13. History of alcohol and/or substance abuse: □Yes □No
14. History of domestic violence: □ Yes □ No
15. Victim of violent crime: □ Yes □ No
16. Addition Children (that did not fit on front side of form):
    Name:______________________ DOB:____________
    Name:______________________ DOB:____________
    Name:______________________ DOB:____________
17. Contact information in case we cannot reach client:

    Name:______________________________
    Relationship:______________________________
    Phone:______________________________

FOR OFFICE USE ONLY

Referred to: ______________________ Date Assigned to Home Visitor: ______________

_____ Access _____ Excel _____ V.T. _____ NFP _____ Faxed

Revised 5/8/15