**Dakota County Referral to Family Health Home Visiting**

**Fax to 651-554-6130 or Email referral to** [PHIntake@co.dakota.mn.us](mailto:PHIntake@CO.DAKOTA.MN.US)

|  |  |
| --- | --- |
| Referral Source/Phone: | Date: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of clients/family members being referred** | | | | | | | **Birth Date** | | | **Sex** | **Race/**  **Ethnicity** | | | | **Referral Reason** | | | |
| First name: | M Initial | | Last name: | | | |  | | |  |  | | | |  | | |  |
|  |  | |  | | | |  | | | M  F |  | | | | PG, EDD: | | | Postpartum |
|  |  | |  | | | |  | | |  |  | | | | Low Birth Weight | | | Premature |
|  |  | |  | | | |  | | |  |  | | | | Other: | | | |
|  |  | |  | | | |  | | | M  F |  | | | | PG, EDD: | | | Postpartum |
|  |  | |  | | | |  | | |  |  | | | | Low Birth Weight | | | Premature |
|  |  | |  | | | |  | | |  |  | | | | Other: | | | |
|  |  | |  | | | |  | | | M  F |  | | | | PG, EDD: | | | Postpartum |
|  |  | |  | | | |  | | |  |  | | | | Low Birth Weight | | | Premature |
|  |  | |  | | | |  | | |  |  | | | | Other: | | | |
|  |  | |  | | | |  | | | M  F |  | | | | PG, EDD: | | | Postpartum |
|  |  | |  | | | |  | | |  |  | | | | Low Birth Weight | | | Premature |
|  |  | |  | | | |  | | |  |  | | | | Other: | | | |
| Foster Parent/ Guardian Name (if not the parent): | | | | | | | | | | | | | | | | | | |
| Family Address: | | | | | | | | | | | | | | | | | | |
| Phone: | | | | | cell home | | | | | Alternate Phone: | | | | | | | cell home | |
| Client may be contacted by: | | | | | | | | | | | | | | | | | | |
| Phone  Text Cell Phone Carrier | | | | | | | | | | | | | E-mail | | | | | |
| We may leave  Recorded message  Message with person | | | | | | | | | | | | | Client / family aware of referral:  Y  N | | | | | |
| Language: | English  Spanish Other: | | | | | | | | | | Interpreter Needed  Y  N | | | | | First time parent:  Y  N | | |
|  | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | |
| ***Intake staff***  ***processing only:*** | | ***MA/Minnesota Care*** | | | | | | | ***PMAP*** | | | | | | | ***Private Insurance*** | | |
| Client Insurance Information | |  | | | | yes  no  PMI # | | | PMAP # | | | UCare  BCBS  HealthPartners | | | | **Carrier:**  **ID:** | | |
|  | |  | | | | yes  no  PMI # | | | PMAP # | | | UCare  BCBS  HealthPartners | | | | **Carrier:**  **ID:** | | |
|  | |  | | | | yes  no  PMI # | | | PMAP # | | | UCare  BCBS  HealthPartners | | | | **Carrier:**  **ID:** | | |
|  | |  | | | | yes  no  PMI # | | | PMAP # | | | UCare  BCBS  HealthPartners | | | | **Carrier:**  **ID:** | | |
| Open to other Dakota County Programs | | yes no   E&EA  PH  SS:(**worker name**) | | | | | | | | | | | | | | | | |
| Mother Primary/Reason | | AP  Par  PP2WK  PP3MO MVS-I MVS-C Other: | | | | | | | | | | | | | | | | |
| Child Primary/Reason | | GRW  ASTH BDIS EHDI LEAD  FAP MVS-I MVS-C Other: | | | | | | | | | | | | | | | | |
| Referral Destination: | | NSC Family Health  WSC Family Health | | | | | | NSC FH Rapid Response  WSC FH Rapid Response | | | | | | | Child Passenger Safety | | | |
| PH Doc #: | | | | Pending: | | | | | | | | | | Intake PHN: | | | | |