LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT
HEALTHY FAMILIES HOME VISITING
Phone: (402) 441-4103 * FAX: (402) 441-6219

REFERRAL FOR HOME VISITATION SERVICES

Date: _______________ Referring Agency ____

Agency Contact Completing Referral ______________________________Phone# _____________________

INFORMATION ON MOTHER

Mother's First Name __________________________

Mother's Last Name __________________________

Date of Birth ________________________________

Street Address _______________________________

City/State ___________________________________

Phone _______________________________________

Due Date ____________________________________

Mother's Provider _____________________________

Race ____________________________ Hispanic ☐ Y ☐ N

Language ________________Interpreter Needed ☐ Y ☐ N

INFORMATION ON BABY*

Baby's First Name __________________________

Baby's Last Name __________________________

Date of Birth ______________________________

Baby's Sex ☐ F ☐ M

Baby's Weight _____________________________

Baby's Discharge Weight ___________________

Breastfeeding ☐ Y ☐ N

Baby's Provider ____________________________

Baby's Race _________________ Hispanic ☐ Y ☐ N

If multiples, fill out a separate form for additional child.

FOR NEW REFERRALS ONLY

A. **Marital Status** (circle): Single, Married, Divorced, Widowed, Separated, Unknown

B. **Answer each of the following statements with T (true), F (false) or U (unknown):**

T F U **1.** Partner unemployed
T F U **2.** Inadequate income or no information regarding source of income
T F U **3.** Unstable housing
T F U **4.** No Phone
T F U **5.** No high school diploma or GED
T F U **6.** Inadequate emergency contacts
T F U **7.** History of substance abuse
T F U **8.** Late prenatal poor compliance
T F U **9.** History of abortion
T F U **10**. History of psychiatric care
T F U **11**. Attempted abortion for this pregnancy
T F U **12**. Relinquishment for adoption sought or attempted
T F U **13**. Marital or family problems
T F U **14.** History of or current mental health issues
T F U **15.** First time mother

C. **Additional Reasons for Referral (Select any that apply):**

☐ CPS Involvement
☐ Limited Support System
☐ Symptoms of Depression
☐ Teen Pregnancy
☐ Basic Needs
☐ Special Needs ____________
☐ Child Development Education
☐ Pregnancy Drug Use
☐ Other ___________________

D. **Notes:** ____

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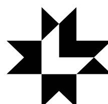
FOR INTERNAL USE ONLY

Date Received _______________
Received By ________________
Date Scanned _______________



Lincoln-Lancaster County Health Department

HFA Home Visitor _________________
Mother Patient # _________________
Baby Patient # ___________________