MATERNAL & CHILD HEALTH REFERRAL

PLEASE FILL OUT **ALL INFORMATION BELOW AND FAX: ATTN Maternal Child Health (503) 325-8678 **

TO: Clatsop County Health Dept.
820 Exchange, Suite 100
Astoria OR 97103
(503) 325-8500
FAX (503) 325-8678

From: _____

Referral Type: ☐ Maternity Case Management ☐ Babies First Program
Due Date: _____

Mother's Name: _____ DOB/Age: _____

Father's Name: _____ DOB/Age: _____

Parent's Marital Status (circle): S M W D Partner Sep Phone: _____ Message: _____

Infant's Name: _____ DOB: _____ Sex: _____

Street Address (if using a PO BOX): _____

MOTHER	INFANT
Pregnancy Hx: G: _____ P: _____ Spon Ab: _____	Delivery: Spont: _____ C/S _____ Reason: _____
Ther Ab: _____ Term Births: _____ Premature Births: _____	APGAR: _____ Gestation: _____
Ages of Living Children: _____	Head Birth Wt: _____ Length: _____ Circum: _____
	Discharge Wt: _____
Reason for Referral: _____	**Reason for Referral:** _____
Medical Diagnosis: _____	Medical Diagnosis: _____
Discharge Date: _____	Discharge Date: _____
Meds/Treatment Instructions: _____	Instructions:
	Feeding: Breast _____ Formula (type): _____
OHP: ☐ Yes ☐ No	Other: _____
PCP: _____	PCP: _____
Follow-Up Appt: _____	Follow-Up Appt: _____
	OHP: ☐ Yes ☐ No

Any Lactation Concerns and/or Interventions: _____

Expecting Public Health Nurse: **Yes** ☐ No ☐

W:\Health\MCH\Forms\Referral Form rev 7/2017

Referring Person- **Printed** Please _____ Date

Contact Phone: