



## PREGNANCY REFERRAL FORM

(Please fax to appropriate county listed below)

Patient/Client Information:					
Name:			Age:	Birthdate:	
Any previous live births? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Delivery Date:	# of Weeks Pregnant:	OB Provider:		
Address:	Apt.:	City:	Zip:	Speaks English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone	OK to Text: <input type="checkbox"/> Yes <input type="checkbox"/> No			If No, specify language:	
E-Mail:		OK to E-Mail: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact Person:	Relationship to Patient/Client:	Cell Phone:	Work Phone:		
<b>Patient agrees to be referred &amp; gives permission to share the information above regarding her pregnancy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
Referring Agency/Practice Information:					
Agency name:			Fax Number:		
Referring Staff Name:		Title:	Phone:		
Staff Signature:		Date:			
Comments:					

**Nurse-Family Partnership (NFP):** Pregnant with risk factors, low-income, residents of Eau Claire, Chippewa or Dunn County



**WIC:** Women, Infant, Children Nutritional Program

To be Completed by the Health Department		
<input type="checkbox"/> Enrolled in NFP      Date of Enrollment: _____ <input type="checkbox"/> Enrolled in WIC      Date of Enrollment: _____ <input type="checkbox"/> Refused to Participate in NFP <input type="checkbox"/> Refused to Participate in WIC <input type="checkbox"/> Unable to Locate <input type="checkbox"/> Ineligible because: <input type="checkbox"/> Did not meet NFP criteria <input type="checkbox"/> Did not meet WIC criteria <input type="checkbox"/> Other: _____		
Staff Signature and Title:	Phone:	Date:

Dunn County HD  
Fax: 715-232-1132  
Phone: 715-232-2388

Eau Claire City-County HD  
Fax: 715-839-1674  
Phone: 715-839-4718

Chippewa County HD  
Fax: 715-726-7910  
Phone: 715-726-7900