Waukesha County Public Health Referral Form

REFERRAL TO: Waukesha County Public Health Division

Fax: (262) 920-6670; **Phone:** (262) 896-8430
Secure Email: publichealth@waukeshacounty.gov

Type of Referral: ☐ Pregnant Parent ☐ Infant/Child ☐ Breastfeeding Support

Referring Agency:_____ **Referring Provider:** _____ **Phone:** _____

CLIENT INFORMATION

IF THE REFERRAL IS FOR **PREGNANT PARENT**, PLEASE COMPLETE THIS SECTION:

Name of Parent: _____
DOB: _____
Address: _____
City & Zip Code: _____
Phone: _____
Primary Language: _____
Ethnicity: Choose One
Race: Choose One
# of Pregnancies: _____
 # Live Births: _____
Estimated Due Date: _____
OB Physician: _____

IF THE REFERRAL IS FOR AN **INFANT, CHILD OR BREASTFEEDING SUPPORT** PLEASE COMPLETE THIS SECTION:

Name of Child: _____
DOB: _____
Address: _____
City & Zip Code: _____
Primary Language: _____
Gender: ☐ Female ☐ Male
Ethnicity: Choose One
Race: Choose One
Parent Name: _____
Phone: _____
Birth Weight: _____ lb. _____oz. Length: _____ in.
Weeks Gestation at birth: _____
Discharge Weight: _____ lbs. _____ oz.
☐ Formula ☐ Breastfeed
Child's Physician: _____

REASON FOR REFERRAL

- ☐ Bonding concerns
- ☐ Breastfeeding support
- ☐ Complications of pregnancy or delivery
- ☐ Depression/Anxiety
- ☐ Dysfunctional factors in family
- ☐ Gestational Diabetes
- ☐ History of family violence
- ☐ Lack of Information on Parenting
- ☐ Lack of support system
- ☐ Language Barrier
- ☐ Late Prenatal Care
- ☐ Limited cognitive/learning ability
- ☐ Mental Health
- ☐ Parental substance use / abuse
- ☐ Risks
- ☐ Severe financial problems
- ☐ Unstable Housing

Additional Information: