JACKSON COUNTY
Health & Human Services

Public Health Service – MCH
140 S Holly St.
Medford, OR. 97501
Phone: 541-774-8209
Fax: 541-774-7977

REFERRAL FOR MATERNITY SERVICES

Email Address to send referral to: HOME_VISITING_MCH@jacksoncounty.org

Today's Date: _____

Client: _____ Age: _____ DOB: _____
Last Name First Name MI

Home Address: _____ 975_____
Street Apartment City Zip Code

Mailing Address: _____

Telephone: _____ Alternate/ Message Phone: _____ **OK to leave message?** ☐ YES ☐ NO E-mail: _____

Text: ☐ Yes ☐ No **Primary Language**: _____

Household/Family Roster:	Age:	Living in Home
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Income: _____

Family Size _____

Health Insurance: ☐ App OHP ☐ OHP ☐ Uninsured ☐ Private **Housing:** ☐ Stable ☐ Living with others ☐ Homeless

***PLEASE* PROVIDE REASON FOR MATERNITY REFERRAL** Client notified of referral? ☐ Yes ☐ No

☐ Substance Use within the past 12 months
Preferred Substance _____ Date Last Used _____
Other Substance _____ Date Last Used _____
Other Substance _____ Date Last Used _____

☐ Depression/Mental Illness. DX _____ Current Medications _____ PHQ-9 Score_____

☐ Domestic Violence within past 12 months ☐ History of Domestic Violence/Child Abuse/Sexual Abuse

☐ Teen Pregnancy. (Age 11-17) **Mandatory Report Done? ☐ Yes ☐ No ☐ N/A**

☐ High Risk Medical: Condition _____ _____ _____

☐ Homeless/Transient Housing

☐ Smoking within past 12 months. Date Last Used _____ Amount per day _____ Desire to quit? ☐ Yes ☐ No

Other Pertinent Information: ☐ Other Home Visiting Programs?_____
☐ Lack of Support Network ☐ Client or Partner in Corrections System ☐ Hx Child Services Case ☐ 1st PNC _____

PRENATAL HISTORY: G _____ P _____ SAB _____ TAB _____ LC _____ EDC: _____
G= Gravida (how many times pregnant) P= Para (how many births after 20 weeks) SAB = Spontaneous Abortion TAB = Therapeutic Abortion LC = Living Children EDC = Estimated Due Date
NOTES: _____

_____

_____

_____

_____

REFERRAL INFORMATION PROVIDED TO PATIENT:

☐ HUD	☐ Healthy Start	☐ Drug & Alcohol	☐ Living Well	☐ Oregon Mothers Care
☐ WIC	☐ Family Planning	☐ Oregon Quit Line	☐ Dunn House	☐Other _____

REFERRAL SOURCE:
Agency/Program: _____ Phone: _____

Name: _____ Date: _____

Patient Label

ADDITIONAL PROGRESS/CLINICAL NOTES

DATE	

Maternity Referral Criteria — Priority

Substance Use within past 12 Months ..... 10 Points
Current Depression/Mental Illness; PHQ-9 Score > 10 _____ ..... 10 Points
Domestic Violence with past 12 Months ..... 10 Points
Young Teen Pregnancy (Age 11 – 14) ..... 10 Points
Mandatory Report Done? ☐ Yes ☐ No ☐ N/A
History of Domestic Violence/Child Abuse/Sexual Abuse ..... 5 Points
Teen Pregnancy (Age 15 – 17) ..... 5 Points
Mandatory Report Done? ☐ Yes ☐ No ☐ N/A
High Risk Medical ..... 2 Points
Late entry into OB care; HX Preterm Labor; Preeclampsia; Mitral Valve Prolapse; Hemophilia; Other Hemato Clotting Factors; Lupus; Graves' Disease; Diabetes; Hypothyroidism
Homeless/Transient Housing ..... 2 Points
Smoking ..... 2 Points

Total Points: _____

Priority Scoring: 1st priority: 15+ Points -- 2nd priority: 10-14 Points -- 3rd priority: 6-9 Points -- 4th priority: 2-5 Points

OFFICE USE ONLY

Client referred to:
☐
☐ Prenatal Babies First
☐ NFP
☐ NFP - MULTIP
☐ NMHS - TPP
☐ Other _____

Date Assigned: _____
Assigned to: _____

Does client have previous JCHHS Record?
☐ Yes ☐ No
If yes, date previously opened: _____

If yes, who was client previously assigned to? _____

Client taken under care for this referral?
☐ Yes – If yes, date: _____

☐ No – If no, NTUC Date: _____
☐ Client Declined Services
☐ Staff Unable to Locate Client
☐ NTUC due to priority scoring
□ Already enrolled in another program
□ Did not meet criteria
□ Program Full

Patient Label