



Montgomery Perinatal Program Home Visiting



- **Nurse Home Visiting:** Home-Based Case Management for 1st-time moms, teens, high-risk (i.e., diabetes, hypertension, history of loss or preterm/low birth weight, substance abuse/behavioral health concerns)
- **Community Health Worker Home Visiting:** Home-based Case Management for pregnant persons with low health literacy, 1st birth in the United States, other social concerns
- **Babies Born Healthy Program:** Home Visiting Care Coordination for African American pregnant persons living in the Silver Spring region of Montgomery County

MONTGOMERY COUNTY MATERNAL CHILD HEALTH HOME VISITING REFERRAL FORM

Today's Date: _____ Name of Person Making Referral: _____

Referring Organization: _____ Email: _____

Phone: _____

Member Demographic Information

First Name: _____ Last Name: _____

Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Street Address: _____ Apt: _____ City, State, Zip: _____

Race: White Black Asian

Client Pregnancy Information

Ethnicity: Hispanic Yes No

Primary Language Spoken: English Spanish Other: _____

Estimated Due Date: _____ Estimated Gestational Age: _____

Current Trimester: 1st 2nd 3rd First Time Parent: Yes No

MRN# _____ Medicaid # _____ MA MCO Name: _____

Qualifying Social and/or Medical Risk Factors

- | | | |
|--|--|--|
| <input type="checkbox"/> History of preterm birth (less than 37 completed weeks) | <input type="checkbox"/> History of low birth weight (less than 2500 grams/5 lbs. 8 oz) | <input type="checkbox"/> Low Health Literacy |
| <input type="checkbox"/> Chronic medical conditions which may complicate pregnancy | <input type="checkbox"/> Current substance/ alcohol use (or use in the month prior to pregnancy) | <input type="checkbox"/> Unsafe living environment (Intimate Partner Violence/abuse /unstable housing/ homelessness) |
| <input type="checkbox"/> Depression/Behavioral health concerns | <input type="checkbox"/> Current tobacco use | <input type="checkbox"/> First Birth in the USA |
| <input type="checkbox"/> History of prior pregnancy loss | <input type="checkbox"/> Teen | <input type="checkbox"/> Advance Maternal Age (<40 years of age) |
| <input type="checkbox"/> Close Child Spacing (Less than 1 year since last pregnancy) | | |
- Other: _____

Notes: _____

Please Email this completed form to

GHReferrals@MontgomeryCountyMD.Gov Or SSHReferrals@MontgomeryCountyMD.Gov