WAKE COUNTY NORTH CAROLINA Health & Human Services

Postpartum Home Visiting Nurse Referral Form

Date:_____

MOTHER'S LAST NAME	MOTHER'S FIRST NAME	MOTHER'S DOB	HOSPITAL MRN	RACE
				☐ White ☐ Pacific Islander ☐ Black ☐ Amer Indian ☐ Asian ☐ Other: _____

DELIVERY TYPE	GRAVIDA / PARA	GESTATION: WEEKS DAYS	NUMBER OF BIRTHS	DELIVERY DATE	SEX
☐ Vaginal ☐ C-Section ☐ VBAC			☐ Single _____ ☐ Twins _____		☐ Male ☐ Female

PREG OUTCOME	WEIGHT: POUNDS OUNCES GRAMS	DELIVERY SITE	PRIMARY LANGUAGE
		☐ WMC Cary ☐ WMC North ☐ WMC Raleigh ☐ UNC CH ☐ Duke ☐ Rex ☐ Other: _____	☐ English ☐ Spanish ☐ Other _____

ADDRESS*(ES)*:	
ALTERNATE ADDRESS	
PHONE*(S)*:	
ALTERNATE PHONE	

PRENATAL CARE SITE	CONTRACEPTIVE	FEEDING TYPE	INSURANCE TYPE
☐ WCHHS-Departure ☐ Shared ☐ WCHHS-MAIN ☐ No Care ☐ WCHHS-ERC ☐ Unsure ☐ WCHHS-SRC ☐ Other _____ ☐ WCHHS-NRC ☐ WMC	☐ BTL ☐ Abstinence ☐ Depo ☐ Implant ☐ Foam & Condom ☐ Signed for BTL ☐ IUD ☐ Unsure ☐ Pills ☐ None ☐ Nuva Ring ☐ Other _____ ☐ Patch ☐ Vasectomy	☐ Breast ☐ Bottle ☐ Both ☐ Unsure	☐ Medicaid ☐ Emergency Medicaid ☐ Private

WCHHS PT ID#	POSTPARTUM SITE	POSTPARTUM APPT.	PROGRAMS
	☐ WCHHS ☐ WakeMed ☐ Private _____	Date _____ Time _____	☐ CMHRP ☐ High Risk Nurse ☐ NFP

INFANT NAME	INFANT WELL CLINIC SITE	GEO TEAM
		☐ North ☐ South ☐ North West ☐ South West ☐ North East ☐ South East ☐ East ☐ OOC

REFERRING ORGANIZATION	ADDITIONAL NOTES