ERIE COUNTY DEPARTMENT OF HEALTH
MCH SERVICE REQUEST

* For MCH use only *
Date Referred (assigned)
Date Authorized (contact with client)

Mother's Name:		**Father's Name:** Is he involved? Y N		**Child 1:**		
DOB:	Insight #:	DOB:	Insight #:	M ☐ F ☐	DOB:	Insight #:
Insurance: (Circle One) CHIP IS MS MH NI Unk		Insurance: (Circle One) CHIP IS MS MH NI Unk		Insurance: (Circle One) CHIP IS MS MH NI Unk		
Race:	Ethnicity:	Race:	Ethnicity:	Race:	Ethnicity	
Address:				**Child 2:**		
City:	State: Zip:			M ☐ F ☐	DOB:	Insight #:
Phone:				Insurance: (Circle One) CHIP IS MS MH NI Unk		
Alternate/Emergency Contact:	Phone:			Race:	Ethnicity	
Physician: Address:	Phone:			☐ Additional children on reverse		
Origin of Referral:	Address:			Phone:		

Is client aware of referral? Y N

Reason for Referral: (detail on reverse)

☐ Pregnancy 1st pregnancy? Yes No EDC: _____ ☐ Cleft - Lip Palate ☐ Lead Poisoning

☐ Postpartum/Infant BW _____ Vaginal C-section ☐ Newborn Metabolic Screening ☐ PKU - Newborn/Maternal

Bottle Breast

☐ Newborn Health Guidance OR Other Child Health Guidance ☐ Newborn Hearing Screening f/u

☐ Medical Neglect/Concern (OCY) ☐ Infant Death DOD _____ ☐Autopsy Results Pending

☐ Other _____ Cause of death (if known): SIDS or Other: _____

☐ Additional info on reverse

Specific concerns/problems: (check all that apply)

☐ Intra Uterine Growth Retardation ☐ Prematurity ☐ Bonding

☐ Substance Exposed Infant ☐ Developmental Delays ☐ Failure To Thrive

☐ Post-Partum Depression ☐ Lice ☐ Other _____

☐ Additional info on reverse

Significant History: (Social, Prenatal/Postpartum, Medical)

☐ Additional info on reverse

Other agency involvement: ☐WIC ☐OCY ☐EI ☐Family Center _____ ☐ MH ☐ MR

HHC Agency (name) _____ Other _____

Call Taken By: **Date:**

Insurance codes: C=CHIP, IS=Insurance Standard/Private, MS = MA-ACCESS-Standard, MH=MA HMO (Gateway, MedPlus), NI=No Insurance

Client Name _____ **MCH SERVICE REQUEST**

Child 3:			**Child 4:**			**Child 5:**		
M ☐ F ☐	DOB:	Insight #:	M ☐ F ☐	DOB:	Insight #:	M ☐ F ☐	DOB:	Insight #:
Insurance: (Circle One) CHIP IS MS MH NI Unk			Insurance: (Circle One) CHIP IS MS MH NI Unk			Insurance: (Circle One) CHIP IS MS MH NI Unk		
Race:	Ethnicity:		Race:	Ethnicity:		Race:	Ethnicity	

Additional info:

Signature

Follow-up NURSES' NOTES

DATE AND TIME	NARRATIVE	SIGNATURE AND TITLE