



COUNTY OF ERIE

DEPARTMENT OF HEALTH



Kathy Dahlkemper,
County Executive

Melissa Lyon, MPH, CPH
Director

Parent & Child Health Nurse Home Visit Referral

Client Name: _____ Date of Birth: _____

Address: _____ Race: _____

_____ Ethnicity: _____

City, State, Zip _____ Insurance: _____ Private/other _____ MA

Phone _____ Okay to text? Yes No

Okay to leave a message? Yes No

Language (If other than English): _____ Interpreter Needed? Yes No

Alternate Contact

Name: _____ Phone: _____

Relationship to Client: _____

Referral Information

First Time Pregnancy? Yes No EDC (Due Date) / Delivery Date _____

Number children: _____ Ages of other Children: _____

OB/GYN Provider or PCP: _____

Referring Agency: _____ Phone: _____

Address: _____ City, State, Zip: _____

Person Referring: _____ Date: _____

Client is: Aware of Referral Interested Wants more information

Additional Information/Reason for Referral:

(Please complete all information)
Please FAX referral to the Erie County Department of Health PCH Program at 814-451-6767