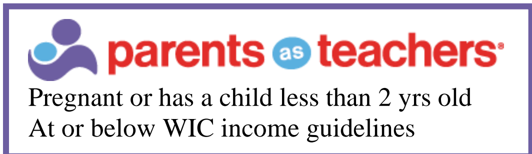
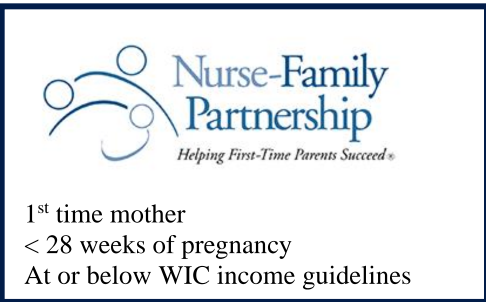


Targeted Case Management
Medicaid or PDG (uninsured/underinsured)
Short term visits



Welcome Baby

Utah County Health Dept

Intake Form Prenatal/Infant/Children

___ BYB ___ NFP ___ PAT ___ P5 ___ PDG ___ TCM

Place of Referral ________________ Insurance ______________ Medicaid # _____________________

Date of Referral _________________ Person making referral __________________________________

Reply requested from referring party? ___ Yes ___ No Phone # _____________________

****

Family Information, fill out as applicable!

Child's Name _________________________ M/F DOB (______________) Weeks Gestation ___________

Feeding _________________ Discharge Date ____________________ OB/PCP _____________________

Mother ____________________________ (______________) Estimated Due Date (_______________)
DOB

Father ____________________________ ( ) Primary Language Spoken in Home___________________
AGE

Address____ City _____________________ Zip __________

Home Phone ____________________________ Email _______________________________________

Special medical, nutritional, or psycho-social concerns ____________________________________

____

____

____

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For Office Use Only

Dates of attempted phone contact ____

Home Visit Scheduled? Y N Date Scheduled ___________________________ Time _______

If no home visit scheduled, note reason and plans for follow-up ___________________________________

____

____

Referral Made? (Specify) _____________________ Follow-up material mailed? Date ________

Home Visitor's Signature ____ Date __________

Send intake info to Judith Almeida, Bureau Director, Utah County Health Dept. 151 South University Avenue Provo, Utah 84601 Email JudithA@utahcounty.gov. **Phone 801-851-7026. Fax: 801-851-7055**

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