Attachment C

Home Visit Referral Form

MaineCare Benefits for Members Under 21
Home Visit Referral Form

Date: _____

Child's Name: _____ MaineCare ID#:_____

Date of Birth: _____ Parent's Name: _____

Address:_____

Telephone: _____ Referred By: _____

Primary Care Provider: _____

Reason for Referral: _____
_____
_____
_____
_____
_____

Health Problems: _____
_____
_____

Disposition:_____
_____
_____
_____
_____
_____
_____

Nurse's Name: _____ Date: _____

Nurse's Signature: _____ Telephone:_____

Maine Department of Health and Human Services,
Maine Center for Disease Control and Prevention, Immunization Program
Key Bank Plaza, 9th Floor, 11 State House Station, Augusta, ME 04333
1-800-867-4775 or 207-287-3746 – TDD/TTY 1-888-706-3876