|  |  |
| --- | --- |
|  | **Community and Nursing Services Division****REFERRAL FORM**FAX: (714) 834-7780 Phone: (714) 834-7747 |

|  |
| --- |
| **REFERRAL SOURCE** |
| **Date of Referral:** |       | [ ]  **Self-Referral** |
| **Your Name:** |       | **Telephone:** | (       )       |
| **Agency:** (if applicable) |       | **Fax:** |       | **Email:** |       |
| **Is Client aware of this Referral?** | [ ]  Yes [ ]  No |
|  |
| **CLIENT INFORMATION** |
| **Client Name:** |       |       | **DOB:** |       | [ ] Male [ ] Female [ ] Other: |       |
|  | First | Last |  |  |
| **If Client above is a child, please provide parent/caregiver name:** |       |
| **Address:** |       |       |       |       |       |
|  | Street | Apt. # | City | State | Zip |
| **Homeless:** (location: shelter/hotel/street name) |       |
| **Language(s) Spoken:** | [ ]  English | **Cell Phone:** |       |
| (check all that apply) | [ ]  Spanish | **Other Phone:** |       |
|  | [ ]  Other:        | **E-mail:** |       |
|  |  |  |  |
| **REASON FOR REFERRAL** |
| **PREGNANCY/POSTPARTUM:** | [ ]  High Risk Pregnancy | [ ]  Pregnancy or Postpartum Complications |
| [ ]  Teen Pregnancy | [ ]  Breastfeeding Problems | [ ]  Other: |       |
|  |  |  |
| **INFANT/CHILD:** | [ ]  Birth Complications | [ ]  Growth and Developmental Concerns |
| [ ]  Health Issues, specify: |       |
|  |  |  |
| **ADULTS:** | [ ]  Unmet Health Needs, specify: |       |
|  | [ ]  Chronic Condition, specify: |       |
|  |  |  |
| **Needs a Public Health Nurse (PHN) to help with:** | [ ]  Managing a medical condition (specify): |       |
| [ ]  Accessing community and/or social resources [ ]  Obtaining medical care [ ]  Health information [ ]  Obtaining health insurance |
| [ ]  Other, specify: |       |
| **Select the referral destination, if known:** [ ]  PACT [ ]  CHAT-H [ ]  NFP [ ]  MHRN [ ]  CalWORKs |
| **PREGNANCY/PRENATAL CARE** |
| **EDC (Due Date):** |       | **Gravida:**       **Para:**        | **Prenatal Care:** [ ]  Yes [ ]  No |
| **Type of Pregnancy:** | [ ]  Single [ ]  Multiple (Twins/Triplets) [ ]  High Risk Pregnancy [ ]  Teen Pregnancy |
|  | [ ]  Pregnancy Complications [ ]  Postpartum Complications [ ]  Breastfeeding Issues |
| **Is Family/Parent aware of pregnancy?** | [ ]  Yes [ ]  No |  |  |
| **Is it OK to call client at listed phone numbers?** | [ ]  Yes [ ]  No | **If Yes, when is the best time to call?** |       |
| Comments: |        |
|  |
| **MENTAL HEALTH & PSYCHOSOCIAL ISSUES** |
| **Mental Health Concerns**[ ]  Yes [ ]  No[ ]  Comments/details:        | **Substance Use**Alcohol: [ ] Current [ ] Hx of Use Smoking: [ ] Current [ ] Hx of UseMarijuana: [ ] Current [ ] Hx of Use Meth: [ ] Current [ ] Hx of UseOther: [ ] Current [ ] Hx of Use Specify:        |
| **EDUCATION & EMPLOYMENT** |
| **Attending School:** | [ ]  Yes [ ]  No | **If Yes, Name of School:** |       |
| **Has IEP/Special Education Services:** | [ ]  Yes [ ]  No | **Other School/Education Concerns:** |       |
| **Currently Employed:** | [ ]  Yes [ ]  No | **Occupation:**        | **Work Hours:**        |
|  |  |  |  |
| Other Comments: |        |
|  |  |  |  |

*R6/4/2021*