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

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| **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: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **ADULTS:** | | | | | | | | | | Unmet Health Needs, specify: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | Chronic Condition, specify: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **MENTAL HEALTH & PSYCHOSOCIAL ISSUES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mental Health Concerns**  Yes  No  Comments/details: | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Substance Use**  Alcohol: Current Hx of Use Smoking: Current Hx of Use  Marijuana: Current Hx of Use Meth: Current Hx of Use  Other: 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: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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*R6/4/2021*