

COMMUNITY AND NURSING SERVICES

Referral Form



FAX: (714) 834-7780
PHONE: (714) 834-7747
EMAIL: PublicHealthNursing@ochca.com

For CalWORKs and CalLearn, contact your SSA case worker.

Date of Referral: _____ Self-Referral

Referral Agency:

Agency: _____ Name: _____

Email: _____ Phone #: _____

Client Name: _____ **Medi-Cal/CIN # (if applicable):** _____

DOB: _____ Male Female Other: _____

Address: _____
Street Apt. # City State Zip Code

Home Phone #: _____ **Mobile Phone #:** _____

Primary Language Spoken: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race: *Select all that apply:* American Indian or Alaskan Native Asian Black or African-American White Native Hawaiian or Other Pacific Islander

Does Client/Parent/Guardian Know About This Referral?: (if applicable) Yes No

Parent/Guardian Name: (if applicable) _____ **Phone #:** _____

Client Population:

Homeless
Location: Shelter Motel Street Car
Cross Streets & City: _____

Pregnant
First-Time Parent? Yes No
Due Date: _____
Prenatal Care? Yes No

Postpartum **Parenting** **Newborn**

Medically High-Risk Newborn
Parent's Name: _____
Parent's DOB: _____
Child's Name: _____
Child's DOB: _____ Gest. Age: _____
Birth Weight: _____
Discharge Weight: _____

Concerns:

Accessing Medical Care
 Breastfeeding
 Education/School
 Financial
 Growth & Development
 Health Coverage/Insurance
 Housing
 Medication
 Mental Health: (Specify) _____
 Substance Use: (Specify) _____
 History Current
 Transportation
 Other: _____

Requested Program, if known: AFLP CHAT-H NFP PACT

Brief Description of Reason for Referral:

For Office Use Only: New: _____ Active—PHN Name/CID #: _____ Inactive—CID #: _____