COMMUNITY AND NURSING SERVICES

Referral Form

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

For 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 ☐ SHOPP BIH

Brief Description of Reason for Referral:

For Office Use Only: ☐ **New**: _______ ☐ **Active**–PHN Name/CID #: ____________________ ☐ **Inactive**–CID #: __________

Rev. 02/10/25