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 ☐ MHRN ☐ NFP ☐ PACT ☐ SHOPP ☐ Perinatal STRENGTH

Brief Description of Reason for Referral:

Rev. 06/26/26

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