Public Health Nursing Division
REFERRAL for a
PUBLIC HEALTH NURSE

Fax: (714) 834-7780
Phone: (714) 834-7747

Office Use Only
FF#: ________________
Clerk's Initials: __________
New: ________________
Active Unit: __________
Inactive: ________________

Date: ____________

REFERRAL SOURCE

☐ Self-Referral

Your Name | Agency (If applicable) | Phone # | Fax #

Client's Name: ____ ☐ Male ☐ Female
☐Adult ☐Child First Name Last Name Date of Birth (DOB)

If client is a child, please provide parent/caregiver name: ______________________________

Address: ____ ☐ Homeless
Number/Street Apt # City Zip

Phone: ________________________ ☐ Home ☐ Work ☐ Cell ☐ Msg ☐ Other ________________________ ☐ Home ☐ Work ☐ Cell ☐ Msg ☐ Other
Primary Phone Alternate Phone

Language spoken:
☐ English ☐ Spanish ☐ Vietnamese ☐ Other ________________

REASON FOR REFERRAL

PREGNANCY/ POSTPARTUM
☐ High Risk Pregnancy
☐ Teen Pregnancy
☐ Other: ____________________
☐ Pregnancy or Postpartum Complications
☐ Breastfeeding Problems

INFANT/CHILD
☐ Health Issues
Specify:__________________
☐ Growth and Developmental Concerns
☐ Birth Complications

ADULTS
☐ Unmet Health Needs
Specify:____________________
☐ Chronic Condition
Specify:______________________________

Needs a Public Health Nurse to help with:

☐ Obtaining medical care
☐ Obtaining health insurance
☐ Health information
☐ Accessing community and/or social resources
☐ Managing a medical condition
☐ Other: ____________________________________

Other Information:

☐ History ☐Current Mental Health Problems
☐ History ☐Current Domestic Violence
☐ History ☐Current Drug Abuse
☐ Other: ____________________________________

Others in family who need a Public Health Nurse

Name: ________________ DOB: ________ ☐ Male ☐ Female Reason for referral: __________________
Name: ________________ DOB: ________ ☐ Male ☐ Female Reason for referral: __________________
Other Information: ____

☐ Additional documents attached