Public Health Nursing Division
Referral for a Public Health Nurse

Fax: (714) 834-7780
Phone: (714) 834-7747
Email: Publichealthnursing@ochca.com

Click on envelope to email completed form.

REFERRAL SOURCE

Date: _____ ☐ Self-Referral (if self-referred, please enter your name and phone number in the red boxes below)

Your Name: _____ Phone #: _____

Agency Name: _____ Fax #: _____

CLIENT INFORMATION

Client's First Name: _____ Last Name: _____ DOB: _____

☐ Male ☐ Female ☐ Other (select from dropdown list) _____ ☐Adult ☐Child

Street Address: _____City: _____ State: ___ Zip: _____

☐ Mailing Address Only_____

☐ Homeless (location: shelter/Hotel/Street Name) _____

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

Primary Phone: _____ ☐Home ☐ Work ☐ Cell ☐ Msg ☐Other

Alternate Phone: _____ ☐Home ☐ Work ☐ Cell ☐ Msg ☐Other

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

Other agencies involved/providing care to client being referred for Public Health Nursing Services:

_____

REASON FOR REFERRAL

Needs a Public Health Nurse to help with:

☐ Health information ☐ Managing a medical condition (specify) _____

☐ Obtaining medical care ☐ Accessing community and/or social resources ☐ Obtaining health insurance

Other information:

Other Information:

☐ History ☐Current Mental Health Problems ☐ History ☐Current Drug Abuse

☐ History ☐Current Domestic Violence ☐ Other: _____

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PRENATAL/POSTPARTUM

☐ High Risk Pregnancy ☐ Pregnancy or Postpartum Complications ☐ Teen Pregnancy ☐ Breastfeeding Problems

Other information:

INFANT/CHILD

☐ Health Issues Specify:_____

☐ Growth and Developmental Concerns ☐ Birth Complications

Other information:

ADULTS

☐ Unmet Health Needs Specify:_____

☐ Chronic Condition Specify:_____

Other information:

Others in family who need a Public Health Nurse

Name: _____ DOB: _____ ☐ Male ☐ Female ☐ Other (select from down drop list)

Reason for Referral: _____

Name: _____ DOB: _____ ☐ Male ☐ Female ☐ Other (select from down drop list)_____

Reason for Referral: _____

Instructions for making referrals:

- Self-referrals are accepted.
- Referrals are accepted from health care providers and other community agencies.
- Home visiting services are most effective when there is a "warm handoff" from the referring party. Please discuss with your client the benefits of home visiting and that you are making the referral.
- Complete the referral form to assist us in triaging the client into the most appropriate program. Provide as much of the requested information as you have available and are able to release according to your protocols.
- Click on the envelope symbol below to automatically attach this form to an email. Our email address will auto populate in the email. You may fax the referral to 714-834-7780.

Click on envelope to email completed form