Public Health Services | Family Health Division
Adolescent Family Life Program (AFLP)

REFERRAL FORM

AFLP is a free and voluntary case management program for Orange County residents meeting the following criteria:
-Expectant and parenting adolescents under age 19 (both moms and dads), and
-Have custody of child or are co-parenting with the custodial parent.

Please complete all known information

Name of Youth: _____DOB: _____Age: _____ Sex: ☒ M ☐ F

Address:_____ City: _____ Zip: _____

Can AFLP program send correspondence to the address? ☐ Y ☐ N

Language Preference: _____Best Phone # to reach youth: _____

Best Phone # to leave message: _____ Name of the person: _____ Relationship to youth: _____

Is client currently pregnant? ☐ Y ☐ N If yes, EDC: _____Prenatal Care? ☐Y ☐ N

Does the parent/guardian know about the pregnancy? ☐ Y ☐ N

If parenting, name(s) of client's child/ren: 1- _____ DOB: _____

2- _____ DOB: _____

Check all that apply: ☐ Domestic violence ☐ Foster child ☐ Probation ☐Sexual assault ☐ Homeless
☐ Physical abuse ☐ Substance abuse ☐ Mental health issues ☐ Medical issues

Service(s) needed: ☐ WIC ☐ CalFresh ☐ Housing ☐ Prenatal/Health Care ☐ School/Tutoring ☐ Legal Services
☐ Child Care ☐ Counseling ☐ Parenting ☐ Other: _____

Additional comments:

Person Making Referral:_____Email: _____

Agency: _____Title: _____Date: _____

Address: _____ Telephone #: _____

Send or Fax Completed Referrals to: AFLP
1725 W. 17th St.
Santa Ana, CA 92706
Phone #: (714) 567-6229
FAX #: (714) 834-8051
Intra-County Mail: Bldg. 50

Thanks for your referral

FOR OFFICE USE ONLY

Assigned to:_____ Date:_____

Screening Score:_____Date:_____ RS notified of disposition: ☐ Y ☐ N By: _____ Date: _____
(Initials)

Waitlist Date:_____ Waitlist Letter sent date: _____

Dismissed from Screening Service Date:_____ ☐ See Screening Dismissal Reason Form