COMMUNITY AND NURSING SERVICES DIVISION

REFERRAL FORM

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

REFERRAL SOURCE

Date of Referral: _____ ☐ Self-Referral

Your Name: _____ Telephone: _____

Agency: (if applicable) _____ Fax: _____ Email: _____

Is Client aware of this Referral? ☐ Yes ☐ No

CLIENT INFORMATION

Client Name: _____ (First) _____ (Last) DOB: _____ ☐ Male ☐ Female ☐ Other: _____

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

Address: _____ (Street) _____ (Apt. #) _____ (City) _____ (State) _____ (Zip Code)

Homeless: (location: shelter/hotel/street name) _____

Language(s) Spoken: (check all that apply) ☐ English ☐ Spanish ☐ Other: _____

Cell Phone: _____

Other Phone: _____

E-mail: _____

Is it OK to call client at listed phone numbers? ☐ Yes ☐ No If Yes, when is the best time to call? _____

REASON FOR REFERRAL

PREGNANCY/POSTPARTUM: ☐ High Risk Pregnancy ☐ Pregnancy Complications ☐ Postpartum Complications

(Type of Pregnancy) ☐ Single ☐ Multiple (Twins/Triplets) ☐ Teen Pregnancy

☐ Breastfeeding Problems ☐ Other: _____

EDC (Due Date): _____ Gravida: _____ Para: _____ Prenatal Care: ☐ Yes ☐ No

Is Family/Parent aware of pregnancy? ☐ Yes ☐ No

Comments:

INFANT/CHILD: ☐ Birth Complications ☐ Growth and Developmental Concerns

☐ Health Issues, specify: _____

ADULTS: ☐ Unmet Health Needs, specify: _____

☐ Chronic Condition, specify: _____

NEEDS HELP WITH:

☐ Managing a medical condition (specify): _____

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

☐ Other, specify: _____

Select the referral destination, if known: ☐ PACT ☐ CHAT-H ☐ NFP ☐ MHRN ☐ CalWORKs

MENTAL HEALTH/SUBSTANCE USE

Mental Health Concerns

☐ Yes ☐ No

☐ Comments/details:

Substance Use

ALCOHOL: ☐ Current ☐ Hx of Use SMOKING: ☐ Current ☐ Hx of Use

MARIJUANA: ☐ Current ☐ Hx of Use METH: ☐ Current ☐ Hx of Use

OTHER: ☐ Current ☐ Hx of Use SPECIFY: _____

EDUCATION/EMPLOYMENT

Attending School: ☐ Yes ☐ No If Yes, Name of School: _____

Has IEP/Special Education Services: ☐ Yes ☐ No Other School/Education Concerns: _____

Currently Employed: ☐ Yes ☐ No Occupation: _____ Work Hours: _____

Other Comments: