Community and Nursing Services
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 below)

Your Name: _____ Phone #: _____

Agency Name: _____ Fax #: _____

CLIENT INFORMATION

Client's First Name: _____ Last Name: _____ DOB: _____
If client is a child, please provide parent/caregiver name: _____

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

Street Address: _____City: _____ State: ____ Zip: _____

☐ Mailing Address Only_____

☐ Homeless (location: shelter/Hotel/Street 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 Community and Nursing Services:

REASON FOR REFERRAL

Needs a Public Health Nurse (PHN) to help with: ☐ Managing a medical condition (specify) _____
☐ Accessing community and/or social resources ☐ Obtaining medical care ☐ Health information ☐ Obtaining health insurance

Select the referral destination if known: ☐ ACT ☐ CHAT-H ☐ NFP ☐ SHOPP

Other information:

Additional Information:

☐ History ☐Current Mental Health Issues ☐ History ☐Current Substance Abuse

☐ History ☐Current Domestic/Family Violence ☐ History ☐Current Intimate Partner Violence

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PRENATAL/POSTPARTUM

☐ High Risk Pregnancy ☐ Pregnancy Complications ☐ Postpartum Complications ☐ Teen Pregnancy
☐ Breastfeeding Issues

Other information:

INFANT/CHILD

☐ Health Issues Specify:_____

☐ Growth and Developmental Concerns ☐ Birth Complications

Other information:

ADULT

☐ Unmet Health Needs Specify:_____

☐ Chronic Condition Specify:_____

Other information:

Others in family who need a Public Health Nurse

Name: _____ DOB: _____ ☐ Male ☐ Female ☐ Other (Choose from list)_____

Reason for Referral: _____

Name: _____ DOB: _____ ☐ Male ☐ Female ☐ Other (Choose from 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 also fax the referral to 714-834-7780.

Click on envelope to email completed form