

COMMUNITY AND NURSING SERVICES

Referral Form



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

For CalWORKs and CalLearn, contact your SSA case worker.

Date of Referral: _____ ☐ Self-Referral

Referral Agency:

Agency: _____ Name: _____

Email: _____ Phone #: _____

Client Name: _____ **Medi-Cal/CIN # (if applicable):** _____

DOB: _____ ☐ Male ☐ Female ☐ Other: _____

Address: _____
Street Apt. # City State Zip Code

Home Phone #: _____ **Mobile Phone #:** _____

Primary Language Spoken: _____

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race: *Select all that apply:*
☐ American Indian or Alaskan Native
☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander

☐ Asian
☐ White

Does Client/Parent/Guardian Know About This Referral?: (if applicable) ☐ Yes ☐ No

Parent/Guardian Name: (if applicable) _____ **Phone #:** _____

Client Population:

☐ **Homeless**

Location: ☐ Shelter ☐ Motel ☐ Street ☐ Car

Cross Streets & City: _____

☐ **Pregnant**

First-Time Parent? ☐ Yes ☐ No

Due Date: _____

Prenatal Care? ☐ Yes ☐ No

☐ **Postpartum** ☐ **Parenting** ☐ **Newborn**

☐ **Medically High-Risk Newborn**

Parent's Name: _____

Parent's DOB: _____

Child's Name: _____

Child's DOB: _____ Gest. Age: _____

Birth Weight: _____

Discharge Weight: _____

Concerns:

☐ Accessing Medical Care

☐ Breastfeeding

☐ Education/School

☐ Financial

☐ Growth & Development

☐ Health Coverage/Insurance

☐ Housing

☐ Medication

☐ Mental Health: (Specify) _____

☐ Substance Use: (Specify) _____

☐ History ☐ Current

☐ Transportation

☐ Other: _____

Requested Program, if known: ☐ AFLP ☐ CHAT-H ☐ NFP ☐ PACT

Brief Description of Reason for Referral:

For Office Use Only: ☐ New: _____ ☐ Active—PHN Name/CID #: _____ ☐ Inactive—CID #: _____