Orange County, CA – Health Care Agency
Public Health Nursing
Fax: (714) 834-7977
Phone: (714) 834-7747

District: _____
FF #: _____
Map Grid: _____
Clerk's Initials: _____
New: _____
Active Unit: _____
Inactive: _____

REFERRAL FORM

Date of Referral: ___/___/_____

Referring Source: _____ (___) _____ (___) _____
Agency | Contact Person | Phone # | Fax #

Client Name: _____ Sex: ☐ M ☐ F DOB: ___/___/_____
Last | First

Mother's Name: _____ DOB: ___/___/_____
Last | First | Mother's Maiden Name

Father's Name: _____ DOB: ___/___/_____
Last | First

Address: _____
Street | Apt # | City | Zip

Homeless ☐ (___) _____ (___) _____ (___) _____
Home Phone | Work Phone | Alternate Number

Language Spoken: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____ ☐ Low/No Literacy

REASONS FOR REFERRAL

☐ Mother/Infant Bonding Issues
☐ Breastfeeding/Feeding Concerns
Prenatal Care ☐ Yes ☐ No
EDC _____
☐ Prematurity
☐ Failure to Thrive
☐ Cesarean Delivery with Complications
☐ Complications/Birth Defects? Specify: _____
☐ History/Current Depression PPD
☐ Teen Mom ☐ First Time Mom
☐ History/Current Drug Use
☐ History/Current Emotional/ Physical Abuse
☐ Other (specify): _____

Chronic Disease: ☐ Diabetes ☐ Hypertension ☐ Obesity ☐ Asthma ☐ Other (specify): _____

☐ Insurance Assistance ☐ Medical Home F/U ☐ Very Limited Resources
☐ Poor Support ☐ Poor Living Conditions ☐ Health/Parent Education

Medical Provider: _____ Phone: (___) _____

Infant Stats: GA at Delivery _____ BW _____ L _____ HC _____ Apgar _____

Children/Teens: HT _____ WT _____ BMI _____

Note additional information related to Public Health Nurse (PHN) visit: _____

Other referrals sent to: _____

☐ Additional documents attached

See Attachment(s) for more information