PUBLIC HEALTH NURSING REFERRAL FORM

Date of Referral:

Referring Agency/Practice

Agency/Practice Name:		Phone:
Address:		Fax:
Referring Staff Name:	Title:	Email:

Condition Prompting Referral

Pregnant ☐ | Postpartum ☐ | Parenting ☐ | High-Risk Infant ☐ | Medical ☐ | Psychosocial ☐
1st Time Mother ☐ | Mother <21 yrs ☐ | 2nd Time Mother With Child <2 yrs ☐

Patient/Client Information

Name:			Age:	DOB:
Address:			Apt:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Emergency Contact:	Relationship to Patient:		Contact's Phone:	
Speaks English: ☐ Y ☐ N	Specify Other Language:		Patient agrees to be referred: ☐ Y ☐ N	
Patient Signature:			Date:	
Pregnant ☐	# Weeks Pregnant:	LMP:	EDD:	Pregnancy Test: ☐ Y ☐ N
Parenting ☐	Child's Name:		Age:	DOB:
Additional Information:				

PHN USE ONLY

Accepted ☐	Refused Services ☐	Unable to Contact ☐	Ineligible ☐	Referrals: CA County ☐ OR ☐
Date Staffed:	MCAH-FN ☐	NFP ☐	MH ☐ AOD ☐ Baby Steps ☐	
Nurse Signature:			Date:	
Comments:				

DEL NORTE COUNTY
PUBLIC HEALTH NURSING
Phone: (707) 464-0861
Fax: (707) 465-6701