Date of Referral:

County of Fresno Department of Public Health
Public Health Nursing Services Referral Form

Child Care Provider Referral

(559) 600-3330/Fax: (559) 455-4705
Email: phnfax@fresnocountyca.gov

Office Use Only
CT - ____________________

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Referring Agency/Provider

Agency Name: **Address:**

City: **Zip Code:** **Contact Person:**

Phone Number: **FAX Number:** Reply Requested? Yes No

Client Information

Child's Last Name: Child's First Name: Sex: Male Female DOB:

Address: City: Zip Code: Phone:

Parent/Guardian: Parent/Guardian DOB: Speaks English? Yes No

Primary Language: Race: Hispanic: Yes No

Presumptive Eligibility: Yes No Medi-Cal:Yes No If yes, choose one:

Child Risk Factors — Identified Risk Factors (any that apply)

Risk Factor				Risk Factor		
Speech/language delay	Yes	No		Repetitive actions	Yes	No
Hearing concerns	Yes	No		Constant motion	Yes	No
Large motor skill delay (running, jumping)	Yes	No		Aggressive (biting, hitting, kicking	Yes	No
Fine motor skill delay (drawing, painting)	Yes	No		Needs constant one on one supervision	Yes	No
Poor balance	Yes	No		Easily angered	Yes	No
Appears detached/lack of interest in surroundings	Yes	No		Unable to calm down	Yes	No
Does not interact with other children/adults	Yes	No		Yells or screams frequently	Yes	No
Isolates from others	Yes	No		Difficulty with transitions	Yes	No
Atypical self-sensory stimulation (repetitive actions such as licking, smelling, etc.)	Yes	No		Atypical sexual behavior for developmental age.	Yes	No

This client has been notified of this referral and gives consent to contact: Yes ☐ No ☐

Additional Reason(s) for Referral