County of Fresno Department of Public Health
Public Health Nursing Services Referral
Child Care Provider Referral
FAX 559-455-4705

Office Use Only
CT - _____

_____

Referral Date:

Print Reset

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: 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)					
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 ☐

Additional Reason(s) for Referral

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Liaison	HRIP	AFLP/MMC	NFP Waitlist	NFP	CHVP-NFP Waitlist	CHVP-NFP	BF	BF Waitlist	I/R	BIH	CC