County of Fresno Department of Public Health

Public Health Nursing Referral Form

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

Office Use Only

CT _____

#_____

Date of Referral: ☐

Reason for Referral: ☐ **Pregnancy** ☐ **Infant** ☐ **Child** ☐ **BIH Pregnancy/Postpartum**

Referring Agency/Provider

Agency Name: | Contact Person:

Address: | Phone#: | Fax#:

City/State: | Zip: | CPSP Providers? ○ Yes ○ No | Reply Requested? ○ Yes ◉ No

Mother Information

Last Name: | First Name: | DOB: | Phone:

Address: | City: | Zip:

Primary Language: | Speaks English? ○ Yes ◉ No | Ethnicity: Hispanic ◉ Yes ○ No Hmong ○ Yes ◉ No

Race (check all that apply): ☐ American/Alaskan Indian ☐ White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Unknown

If client is under 18, is parent aware of pregnancy? ◉ Yes ○ No

◉ Medi-Cal ○ Presumptive Eligibility ○ Private Insurance ○ CCS

PNC: ◉ No prenatal care (0 to 3 visits) ○ Late (>16 wks) ○ Frequent Missed Appointments ○ High Risk Pregnancy

First Time Mother: ◉ Yes ○ No Due Date: | # of Pregnancies: | # of Children Living:

Postpartum Delivery Date:

This client has been notified of this referral & gives consent to contact: ◉ Yes ○ No

Infant/Child Information

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

Address: | City: | Zip:

Primary Language: | Speaks English? ○ Yes ○ No | Ethnicity: Hispanic ○ Yes ○ No Hmong ○ Yes ○ No

Race (check all that apply): ☐ American/Alaskan Indian ☐ White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Unknown

○ Medi-Cal ○ Presumptive Eligibility ○ Private Insurance ○ CCS

Gestation: 0 wks 0 days Birth Weight: 0 lbs. 0 oz.

Primary Guardian/Caregiver Name: | Phone: | DOB:

Primary/Guardian Relationship(If not Biological Mom): ○ Biological Father ○ Grandparent ○ Foster ○ Other:

Additional Information (add additional pages if needed)

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