

**Baby & Me**

**Phone: 209-754-6460**

**FAX: 209-754-1709**

Calaveras County Public Health Services

**Maternal Child Infant Public Health Nurse Referral Form**

Referred by: Referred Date: / /

Organization:

Phone: Fax:

This referral is for: ❑ Antepartum ❑ Postpartum ❑ Infant

**Client Information**

First Name: Last Name:

Date of Birth: Age: Preferred Language:

Parent Name (if applicable):

Street Address: City: State/Zip:

Mailing Address: City: State/Zip:

Phone: Okay to leave a message: ❑ Yes ❑ No

Medical Insurance: ❑ Yes ❑ No Due Date or Child’s Birth Date (Circle one and enter date):

Prenatal Care: ❑ Yes ❑ No Provider of PNC: Date of 1st prenatal care visit:

**Client Needs**

|  |  |  |
| --- | --- | --- |
| ❑ A Public Health Nurse Home Visit  ❑ Breast feeding follow up/support ❑ Substance Use Services  ❑ Prenatal Care ❑ Food ❑ Parenting Classes  ❑ Medical Insurance (Pregnant Woman) | ❑ Financial Aid (CalWorks)  ❑ WIC/Food  ❑ Transportation  ❑ Mental Health Services | ❑ Substance Use Services  ❑ Parenting Classes  ❑ Employment / Education  ❑ Other (describe below) |

**Comments:** (Please provide any information that may help the receiving agency assist this client.)

❑ Send report of Public Health Nurse home visit to referring party.

**Check One:**

❑ I (client name) consent to being referred to the Baby & Me Public Health Nurse Home Visiting Program for the indicated services.

❑ Client is unavailable to sign to refer but has verbally consented to referral to the Baby & Me Public Health Nurse Home Visiting Program for the indicated services.

Referring Party Signature: Date:

Date received by CCPHS PHN \_\_\_\_\_\_\_\_\_\_\_\_ PHN Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_