



Family First

PARTNERING WITH FAMILIES FOR HEALTH AND WELLBEING

Referral for Public Health Nurse Home Visiting Services

(530) 283-6330
Fax: (530) 283-6110

1-800-801-6330 Toll-Free
<http://bit.ly/FamilyFirstPC5>

Date: _____ From Provider/Agency: _____

Contact Person: _____ Phone: _____ Fax: _____

Is An Interpreter Needed? Yes No
Is Your Client Aware of This Referral? Yes No

CLIENT INFORMATION

Pregnant (Due Date) Teen (18 & Under) Child (Age) Other

Client Name: _____ Date of Birth: _____

If Minor, Parent/Guardian: _____

Street Address, City, Zip: _____

Mailing Address: _____

Phone: _____ Message Phone/ Name _____

REASON FOR REFERRAL

Access Medical Services Access Health Ins./Other Resources
 Health/Development Concerns ATOD/ Recovery Resources
 Health Information (Specify in Comments) Young Parent / Student
 Other/Additional Concerns or Relevant Information:

Comments:

REFERRAL/STATUS/OUTCOME - (Completed by Public Health Nursing Staff)

<input type="checkbox"/> Assigned to Case Manager:	Date Client Contacted: _____	Initial Visit Scheduled: _____
<input type="checkbox"/> Client Declined to Participate	<input type="checkbox"/> Client Already Participating in:	
<input type="checkbox"/> Unable to Locate Client or No Response to Repeated Attempts to Contact		
<input type="checkbox"/> Other:		

Comments:

PUBLIC HEALTH NURSING SIGNATURE: _____ **DATE:** ____/____/____