



# Public Health Nurse Referral Form



**Fax Referrals to:**

Public Health Nursing  
Attention: Intake Unit  
Phone: (925)608-5100  
Fax: (925)608-5111

Referral will be reviewed and referred to PHN if appropriate.

Date of Referral: \_\_\_\_\_

Client Name: \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City/Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Ethnicity: \_\_\_\_\_  Male  Female DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary Language Spoken:  English  Spanish  Other: \_\_\_\_\_ MRN: \_\_\_\_\_

Emergency Contact Information Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician (if known): \_\_\_\_\_ Phone: \_\_\_\_\_

Where do they go for medical/health needs? \_\_\_\_\_

Health Coverage: \_\_\_\_\_

Does client/parent know about this referral?  Yes  No

Client Population:

Needs Linkage to:

Perinatal (EDD \_\_\_\_\_)

Postpartum/Newborn

Mother's Name \_\_\_\_\_

Mother's D.O.B. \_\_\_\_\_

Baby's name \_\_\_\_\_

Baby's D.O.B. \_\_\_\_\_ Sex: M or F

Gest age (wks) \_\_\_\_\_

Delivery Type: Vag / C-Sec / Vac / VBAC

BW \_\_\_\_\_ DW \_\_\_\_\_

Lactation Concerns: \_\_\_\_\_

Pediatrics

Adult (>18 years)

Family at Risk (Social Issues)

Homeless

Communicable Disease (HIV/AIDS)

Mental Health

Substance abuse services/resources

Developmental Services/ ASQ

School District

Health Coverage

Medical Services/Specialty Care/Accessing medical appts

Vision services/resources

Dental Services/resources

Pharmacy

Transportation

Other: \_\_\_\_\_

Brief Description of reason for referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referral Source (Please print):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Program: \_\_\_\_\_