CONTRA COSTA
HEALTH SERVICES

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.

Public Health Nurse Referral Form

PHN Public Health Nursing

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:

- ☐ 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)

Needs Linkage to:

- ☐ 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: _____