INTER-AGENCY REFERRAL FORM
Family Health Services – Home Visiting Programs
Resource Line: 1-888-840-0889
Fax #: 1-650-573-2042

Date:

REFERENT INFORMATION:

Your Name: Your Phone #:

Your Agency: Your Fax #:

Your Email:

CLIENT INFORMATION

Client Name: DOB: Language:

Address: Zip Code:

Cell Phone #: Home Phone #: MEDI-CAL #:

Race: Ethnicity:

Expected Due Date: Pregnancies: # Live Births: Next OB Appt Date:

Parent's Name (IF CLIENT IS A CHILD): Parent's DOB:

ADDITIONAL INFORMATION

Client aware of referral? Confidential Pregnancy? BCAP Score

Client interested in WIC services? Client interested in WIC Breastfeeding support?

Past/current alcohol/other drug history? Client identifies as Pacific Islander or of African descent?

Client is father to child 0-5(DADS Program)? Client has seen dentist in last 6 months?

Why are you referring for home visiting services?

FOR INTERNAL USE ONLY

EHR CLIENT #: EHR FAMILY #: NEW PENDING OPEN CLOSED

BIH DADS PEDS NFP HFA/PRE-3 DENTAL LEAD CM NAME:

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