County of Fresno Department of Public Health
Public Health Nursing Referral Form
(559) 600-3330 Fax: (559) 455-4705 Email: phnfax@fresnocountyca.gov

Office Use Only
CT _____
#_____

Date of Referral: ☐

Reason for Referral: ☐ **Pregnancy** ☐ **Infant** ☐ **Child** ☐ **BIH Pregnancy/Postpartum**

Referring Agency/Provider

Agency Name: Contact Person:

Address: Phone#: Fax#:

City/State: Zip: CPSP Providers? ◯ Yes ◯ No Reply Requested? ◯ Yes ◯ No

Mother Information

Last Name: First Name: DOB: Phone:

Address: City: Zip:

Primary Language: Speaks English? ◯ Yes ◯ No | Ethnicity: Hispanic ◯ Yes ◯ No Hmong ◯ Yes ◯ No

Race (check all that apply): ☐ American/Alaskan Indian ☐ White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Unknown

If client is under 18, is parent aware of pregnancy? ◯ Yes ◯ No

◯ Medi-Cal ◯ Presumptive Eligibility ◯ Private Insurance ◯ CCS

PNC: ◯ No prenatal care (0 to 3 visits) ◯ Late (>16 wks) ◯ Frequent Missed Appointments ◯ High Risk Pregnancy

First Time Mother: ◯ Yes ◯ No Due Date: # of Pregnancies: # of Children Living:

Postpartum Delivery Date:

This client has been notified of this referral & gives consent to contact: ◯ Yes ◯ No

Infant/Child Information

Child's Last Name: Child's First Name: DOB: Sex: ◯ Male ◯ Female

Address: City: Zip:

Primary Language: Speaks English? ◯ Yes ◯ No | Ethnicity: Hispanic ◯ Yes ◯ No Hmong ◯ Yes ◯ No

Race (check all that apply): ☐ American/Alaskan Indian ☐ White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Unknown

◯ Medi-Cal ◯ Presumptive Eligibility ◯ Private Insurance ◯ CCS

Gestation: 0 wks 0 days Birth Weight: 0 lbs. 0 oz.

Primary Guardian/Caregiver Name: Phone: DOB:

Primary/Guardian Relationship(If not Biological Mom): ◯ Biological Father ◯ Grandparent ◯ Foster ◯ Other:

Additional Information (add additional pages if needed)