Clear Form

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County of Fresno Department of Public Health
Public Health Nursing Services Referral
Infant/Child Services Referral
FAX 559-455-4705

Office Use Only
CT - _____
_____

Date of Referral:

Referring Agency/Provider

Agency Name: Address:

City: State: Zip Code:

Contact Person: Phone Number: FAX Number:

Client Information

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

Address: City: Zip: Phone:

Parent/Guardian Parent/Guardian DOB: Primary Language:

Race: Presumptive Eligibility: ☐ Yes ☐ No

Medi-Cal: ☐ Yes ☐ No If yes, choose one: Speaks English? ☐ Yes ☐ No Hispanic: ☐ Yes ☐ No

Identified Risk Factors (any that apply)

Infant Risk Factors		Maternal Risk Factors	
SGA / IUGR	☐ Yes ☐ No	No Prenatal Care/Late Prenatal Care	☐ Yes ☐ No
Tox Screen done (note results below)	☐ Yes ☐ No	Drug Use	☐ Yes ☐ No
Parent refused tox screen	☐ Yes ☐ No	Tox Screen done (note results below)	☐ Yes ☐ No
Premature Birth	☐ Yes ☐ No	Uses Tobacco?	☐ Yes ☐ No
Congenital Anomaly	☐ Yes ☐ No	Medically High Risk (describe below)	☐ Yes ☐ No
Persistent Respiratory Problems	☐ Yes ☐ No	Mental Health Diagnosis or on Meds	☐ Yes ☐ No
Persistent Feeding Problems	☐ Yes ☐ No	Barriers to learning	☐ Yes ☐ No
Discharged on monitor(s)	☐ Yes ☐ No	Questionable bonding/parenting	☐ Yes ☐ No
Discharged on medication(s) (list below)	☐ Yes ☐ No	Difficult home situation and/or abuse	☐ Yes ☐ No
Birth Wt. Length		Delivery:	☐ Vag ☐ CS
Disch Wt PMD		CPS referral / involvement	☐ Yes ☐ No

Additional Information (add additional pages if needed)

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Liason	HRIP	AFLP/MMC	NFP Waitlist	NFP	CHVP-NFP Waitlist	CHVP-NFP	BF	BF Waitlist	FHN	BIH	CC

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