



County of Fresno Department of Public Health
Public Health Nursing Services Referral
Child Care Provider Referral
FAX 559-455-4705

Office Use Only
CT - _____

Date of Referral: _____

Referring Agency/Provider

Agency Name: _____ **Address:** _____
City: _____ **Zip Code:** _____ **Contact Person:** _____
Phone Number: _____ **FAX Number:** _____

Client Information

Child's Last Name: _____ **Child's First Name:** _____ **Sex:** Male Female **DOB:** _____
Address: _____ **City:** _____ **Zip Code:** _____ **Phone:** _____
Parent/Guardian: _____ **Parent/Guardian DOB:** _____ **Speaks English?** Yes No
Primary Language: _____ **Race:** _____ **Hispanic:** Yes No
Presumptive Eligibility: Yes No **Medi-Cal:** Yes No **If yes, choose one:** _____

Child Risk Factors Identified Risk Factors (any that apply)

Speech/language delay	Yes	No	Repetitive actions	Yes	No
Hearing concerns	Yes	No	Constant motion	Yes	No
Large motor skill delay (running, jumping)	Yes	No	Aggressive (biting, hitting, kicking)	Yes	No
Fine motor skill delay (drawing, painting)	Yes	No	Needs constant one on one supervision	Yes	No
Poor balance	Yes	No	Easily angered	Yes	No
Appears detached/lack of interest in surroundings	Yes	No	Unable to calm down	Yes	No
Does not interact with other children/adults	Yes	No	Yells or screams frequently	Yes	No
Isolates from others	Yes	No	Difficulty with transitions	Yes	No
Atypical self-sensory stimulation (repetitive actions such as licking, smelling, etc.)	Yes	No	Atypical sexual behavior for developmental age.	Yes	No

Additional Reason(s) for Referral

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Liaison	HRIP	AFLP/MMC	NFP Waitlist	NFP	CHVP-NFP Waitlist	CHVP-NFP	BF	BF Waitlist	I/R	BIH	CC