Clear Form

Print Form

County of Fresno Department of Public Health
Public Health Nursing Services Referral
Pregnancy Services Referral
FAX 559-455-4705

Office Use Only
CT - _____
_____

Date of Referral:

Referring Agency/Provider

Agency Name:	Contact Person:
Address:	Phone# FAX #:
State Zip	CPSP Providers? Yes No Reply Requested? Yes No

Reason for Referral: ☐ High Risk Pregnancy ☐ First Time Mother Other:

Client Information

Last Name: First Name: DOB: Phone:

Address: City: Zip: Primary Language:

17 Years or Younger: Is parent aware of pregnancy? ☐ Yes ☐ No Speaks English? ☐ Yes ☐ No Hispanic: ☐ Yes ☐ No

Race: Medi-Cal: ☐ Yes ☐ No If yes, choose one:

Required Information

Presumptive Eligibility: ☐ Yes ☐ No Due Date: LMP # of Pregnancies: # Of Children Living:

Identified Risk Factors (any that apply)

OB Provider (yes/no)	☐ Yes ☐ No	Drug Use (past or present)	☐ Yes ☐ No
Name of OB Provider:		Uses Tobacco	☐ Yes ☐ No
Date of next pre-natal visit:		Exposed to 2nd hand smoke	☐ Yes ☐ No
Weeks at Entry		Positive PPD with abnormal chest X-ray	☐ Yes ☐ No
Medically High Risk (describe below)	☐ Yes ☐ No	Barriers to learning	☐ Yes ☐ No
Mental Health Diagnosis or on Meds	☐ Yes ☐ No	No Support System	☐ Yes ☐ No
Difficult home situation and/or abuse	☐ Yes ☐ No	Extremely limited financial resources	☐ 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

Rev. 1/24/2018