MERCED COUNTY
DEPARTMENT OF PUBLIC HEALTH

Merced County Department of Public Health
Maternal Child Adolescent Health Services Referral

Date of Referral:	
Referring Agency / Provider	
Referred By:	**Contact Person:**
Phone:	**Fax:**

Condition Prompting Referral	
☐	**Public Health Nurse / Field Nurse - (Medically Fragile Infants / Children with Complex Health Issues)**
☐	**Adolescent Family Life Planning/Young Parents Program (AFLP/YPP)-Pregnant or Parenting Teen 18 yrs or less**
☐	**Healthy Families America (HFA) - Pregnant or Parenting baby under 2 mo. Old**

Client Information		
Client is aware of this Referral: ☐ Yes ☐ No	**Ok to leave message?** ☐ Yes ☐ No	
Last Name:	**First Name:**	
Gender: ☐ Male ☐ Female	**DOB:**	
Less than 18 yrs: Consent to Inform? ☐ Yes ☐ No		
Note: Provider is not permitted to inform a parent or legal guardian without the minor's consent.		
Address:	**City:**	**Zip:**
Phone:	**Message Phone if applicable:**	
Speaks English: ☐ Yes ☐ No	**Preferred Language:**	**Ethnicity:**

Insurance Information	
Insurance Type:	**Insurance ID number:**
☐ **Dose not have Insurance or MediCal**	☐ **Would like Insurance enrollment assistance**

Parent or Guardian information if Client is a Minor		
Last Name:	**First Name:**	**DOB:**
Address Same As Above: ☐ Yes	**Address if different from Client:**	
City:	**State:**	**Zip:**
Phone if different from Client:		

Identified risk Factors / Health Information	
Infant Information	***Antepartum / Postpartum Information***
DOB:	**EDC:**
Birth Weight:	**Planned Pregnancy:** ☐ Yes ☐ No
Discharge Weight:	**Month Entered Prenatal Care:**
TOX Screen Done: ☐ Yes ☐ No **Parent Refused:** ☐	☐ **No Prenatal Care**
TOX Screen Results:	☐ **Drug Use in Past 2 Years**
☐ **Premature Birth** **WKS:**	**Drug(s) Used:**
☐ **Congenital Anomaly**	☐ **Risk for Postpartum Depression**
Describe:	**Scale:** **Score:**
☐ **Persistent Respiratory Problems**	**Other Mental Health Risk or DX:**
☐ **Persistent Feeding Problems**	
☐ **CPS Referral / Involvement**	☐ **Medically High Risk/Delivery Complications**
Describe:	**Describe:**

Other notes / Risks:			
G:	**P:**	**SAB:**	**Living:**

☐ **Check here if you are requesting referral response. Please complete all fields applicable to the client before faxing 209-724-4011. PLEASE SEE INSTRUCTIONS ON PAGE 2 OF 2**

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Referral Agency and Provider Information:

- Organization: Complete name of agency making referral
- Referred Date: Date client was referred
- Contact Person: name of person making referral
- Email, Phone, Fax number of the person making referral

Client Contact Information:
Contact information of person being referred. Please complete all contact information, if unknown or not applicable, please specify UNKNOWN or N/A

Programs Available:
(Please check which program you would like to refer client to. If unknown check "Other")

- **Medically Fragile Infants/Children with Complex Health Issues - Public Health Nursing –** Public Health nurse home visiting services and assistance to families with prenatal, postpartum, newborn and child health issues.

- **Adolescent Family Life Program (AFLP) / Young Parents Program (YPP) –** Case management support services for pregnant and parenting teens 19 years or under

- **Healthy Families America (HFA) –** Home visiting case management services for pregnant or up to 2 months postpartum women, serving families up to the child's 3rd birthday.

Other Agency's/Programs Involved: Please list any other referrals you made for this client to increase service coordination.

Additional Information: Please provide detailed information that would help the receiving agency work with this client.