## SOLANO COUNTY HEALTH & SOCIAL SERVICES BLACK INFANT HEALTH PROGRAM CLIENT REFERRAL/INTAKE

Vallejo ◊		Fairfield			
355 Tuolumne St / MS 20-210 Vallejo CA 94590 Phone: (707) 553-5055 Fax: (707) 553-5056		275 Beck Ave / MS 5-240 Fairfield CA 94533 Phone: (707) 784-8770 Fax: (707) 421-6682			
INTAKE DATE:	_INTAKE NAME:				
REFERRED BY:	PHONE:_				
ADDRESS:					
⇔⇔⇔⇔⇔⇔⇔⇔⇔	$\Rightarrow \Leftrightarrow \Leftrightarrow$				
CLIENT NAME:					
DOB:SSN:_		_ETHNIC:			
ADDRESS:	ZIP:	PHONE:			
EMERGENCY CONTACT /(N	Jame/Phone)				
GESTATION WEEK:	EDC DATE:	FRIST EXAM			
PRENATAL CARE? YESN	OWHERE:				
(Referral co	omments about the Client/l	Pregnancy)			
<u>Cc</u>	onsent for Release of Information	<u>on</u>			
I give my permission for theBIH Program. I also give my permissi attend the program.	to release personal on to the to co	I information described above to the ontact the BIH Program to find out if I			
Print Client Name		Date:			
Client Signature:	Staff Signature:				

## FOLLOW-UP REPORT TO REFERRAL AGENCY

CLIENT NAN	VIE:		REFERRED	BY:	
REFERRED 7	ГО: WIC:	AFDC:	OTHER:		
		FOR BIH STAF	F USE ONLY		
DATE			COMMENTS		