CONFIDENTIAL REFERRAL FORM

Solano County Maternal, Child & Adolescent Health Services
Fax: 707-784-2229
Toll-Free Phone: 1-877-680-2229

Referral Source:

Organization: Referred Date:

Referred by: Phone:

Email: Fax:

Contact Information:

Client is aware of this referral? ☐Y ☐N OK to leave message? ☐Y ☐N

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip: _____

Preferred Language: _____ Ethnicity: _____ Relationship to client: _____

Home Phone: _____ Alternate Phone: _____ Gender: ❒ M ❒ F

First Time Mom: ❒Y ❒N Pregnant ❒Y ❒N Prenatal Care: ❒Y ❒N Due Date: _____

Medical Insurance: ❒Y ❒N Medi-Cal ❒Y ❒N Medi-Cal Number: _____

Child First Name: _____ Last Name: _____ Date of Birth: _____

Child's Medi-Cal Number: _____ Gender: ❒ M ❒ F

Programs Available:

☐ Adolescent Family Life Program (AFLP)	☐ Healthy Families America (HFA)
☐ BabyFirst Solano (BFS)	☐ Nurse Family Partnership (NFP)
☐ Black Infant Health (BIH)	☐ Public Health Nursing (PHN)
☐ Child Health & Disability Prevention (CHDP)	☐ Sudden Infant Death (SIDS)
☐ Childhood Lead Poisoning Prevention (CLPPP)	☐ Other_____
☐ Family Strengthening (FSP)	

I am aware my personal information may be shared with Solano County Maternal, Child & Adolescent Health Bureau for referral purposes.

Signature of Client:_____ ☐ Client was verbally advised of referral

Additional Information:

Comments: (please provide detailed information that would help the receiving agency work with this client)

_____

_____

_____

_____

_____

☐ **Check here if you are requesting referral response**

ALL FIELDS NEED TO BE COMPLETED before faxing this form to: 707-784-2229

PLEASE SEE INSTRUCTIONS ON PAGE 2 OF 2

Solano County Maternal, Child and Adolescent Health Services
Confidential Referral Form Instructions

Completed referral should be faxed to 707-784-2229

Referral Source:

- Organization: complete name of agency making referral
- Referred Date: Date client was referred
- Referred by: Name of person making referral
- Phone, Email and Fax Number of person making referral

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")

- **Adolescent Family Life Program (AFLP)** – Case management support services for pregnant and parenting teens 18 yrs. or under

- **BabyFirst Solano (BFS)** – Linkage to healthcare provider, resources and support for pregnant and up to 3 months post-partum women

- **Black Infant Health (BIH)** – Case management support services for pregnant African-American Vallejo residents, 18 and over

- **Child Health & Disability Prevention (CHDP)** –Well child exams for uninsured 0-19 yrs. and Medi-Cal insured 0-21 yrs.

- **Childhood Lead Poisoning Prevention (CLPPP**) – Public Health nurse case management services to children (0-18 yrs.) with elevated blood lead levels

- **Family Strengthening (FSP**) – Public Health nurse home visiting services for children 0-5 yrs. with involvement in Child Welfare Services

- 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

- **Nurse-Family Partnership (NFP**) – Public Health nurse home visiting program for first time moms referred prior to 28th week of pregnancy; Public Health nurse follows family through the child's 2nd birthday

- **Public Health Nursing (PHN**) – Public Health nurse home visiting services and assistance to families with prenatal, postpartum, newborn and child health issues

- **Sudden Infant Death Syndrome (SIDS**) – Public Health nurse home visiting services to provide educational support for families suffering a SIDS death

- **Other**– please specify referral need

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