

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: _____ Issue Date: _____
Child First Name: _____ Last Name: _____ Date of Birth: _____
Child's Medi-Cal Number: _____ Issue Date: _____ Gender: M F

Programs Available:

<input type="checkbox"/> Adolescent Family Life Program (AFLP)	<input type="checkbox"/> Nurse Family Partnership (NFP)
<input type="checkbox"/> BabyFirst Solano (BFS)	<input type="checkbox"/> Public Health Nursing (PHN)
<input type="checkbox"/> Black Infant Health (BIH) Group	<input type="checkbox"/> Sudden Infant Death (SIDS)
<input type="checkbox"/> Childhood Lead Poisoning Prevention (CLPPP)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Healthy Families Solano (HFS)	

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) Group** – Support in a group setting for African-American/Black, pregnant and/or parenting women, 18 yrs. and over.
- **Childhood Lead Poisoning Prevention (CLPPP)** – Public Health nurse case management services to children (0-18 yrs.) with elevated blood lead levels
- **Healthy Families Solano (HFS)** - Home Visiting case management services for pregnant or up to 2 months postpartum women, serving families up to the child's 3rd birthday. Two additional HFS services are now provided for those who qualify as specified below:
 - **BIH HFS:** HFS case management services for African American/Black women provided through BIH programming.
 - **CalWORKs Home Visiting (HVP) Program:** HFS case management services for participants enrolled in the CalWORKs program.
- **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.