



Public Health Nursing Division
Referral for a Public Health Nurse

Fax: (714) 834-7780
Phone: (714) 834-7747
Email: publichealthnursing@ochca.com

Click on envelope to email completed form.

REFERRAL SOURCE

Date: (click here to enter date) Self-Referral (if self-referred, please enter your name and phone number in the red boxes below)

Your Name: Phone #:

Agency Name: Fax #:

CLIENT INFORMATION

Client's First Name: Last Name: DOB:

If client is a child, please provide parent/caregiver name:

Male Female Other (select from dropdown list) Adult Child

Street Address: City: State: Zip:

Mailing Address Only

Homeless (location: shelter/Hotel/Street Name)

Primary Phone: Home Work Cell Msg Other

Alternate Phone: Home Work Cell Msg Other

Language spoken: English Spanish Vietnamese Other

Other agencies involved/providing care to client being referred for Public Health Nursing Services:

REASON FOR REFERRAL

Needs a Public Health Nurse (PHN) to help with: Managing a medical condition (specify)

Accessing community and/or social resources Obtaining medical care Health information Obtaining health insurance

Select the referral destination if known: ACT CHAT-H NFP SHOPP

Other information:

Additional Information:

History Current Mental Health Issues History Current Substance Abuse
History Current Domestic/Family Violence History Current Intimate Partner Violence

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PRENATAL/POSTPARTUM

- High Risk Pregnancy Pregnancy Complications Postpartum Complications Teen Pregnancy
 Breastfeeding Issues

Other information:

INFANT/CHILD

- Health Issues Specify: _____
 Growth and Developmental Concerns Birth Complications

Other information:

ADULT

- Unmet Health Needs Specify: _____
 Chronic Condition Specify: _____

Other information:

Others in family who need a Public Health Nurse

Name: _____ DOB: _____ Male Female Other (Choose from list) _____

Reason for Referral: _____

Name: _____ DOB: _____ Male Female Other (Choose from list) _____

Reason for Referral: _____

Instructions for making referrals:

- Self-referrals are accepted.
- Referrals are accepted from health care providers and other community agencies.
- Home visiting services are most effective when there is a “warm handoff” from the referring party. Please discuss with your client the benefits of home visiting and that you are making the referral.
- Complete the referral form to assist us in triaging the client into the most appropriate program. Provide as much of the requested information as you have available and are able to release according to your protocols.
- Click on the envelope symbol below to automatically attach this form to an email. Our email address will auto populate in the email. You may also fax the referral to 714-834-7780.

Click on envelope to email
completed form