Maternal & Child Health / Public Health Nursing Referral
County of Sonoma, Department of Health Services

Phone: 707-565-4440 **Referral** Fax: 707-565-4430

Mother's Name_____ AKA_____ DOB _____
Last First

Medi-Cal number _____ (IMPORTANT) Other Health Insurance _____ Policy_____

Address_____ City _____Zip Code: _____

Cell Phone _____ Message Phone: _____ Contact Name _____

Father of the Baby: _____ Involved ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No Due Date: _____ ☐Post-partum / Parenting ☐Breast feeding / Formula / Both

Child's Name: _____ DOB: _____ ☐Male / Female

Child's Medi-Cal number: _____ Other Health Insurance: _____

Birth Weight: _____ Gestational Age: _____ 1st child to family ☐ Yes ☐ No

Substance Exposed Birth: ☐ Yes ☐ No Tox. Screen Results: _____

Primary language spoken: _____ Ethnicity _____ is client aware of referral? ☐ Yes ☐ No

Risk Factors:

- ☐ Late Prenatal Care / Missed Appointments
- ☐ Hx: Substance Use
- ☐ Hx: Tobacco Use
- ☐ Poor Social Support/Financial Situation
- ☐ Mental Health Issues
- ☐ Other:
- ☐ Hx Abuse/Neglect
- ☐ Domestic Violence
- ☐ Homeless
- ☐ Unstable Medical Condition

_____

_____

_____

Please provide the following information:

Referred by (Agency Name): _____ Contact Person _____

Phone _____, ext. _____ E- mail: _____

Physician Name and Contact Info: _____

Would you like a call after the 1st visit? ☐ Yes ☐ No Call with updates ☐ Yes ☐ No

Office Use Only

Reason for Referral : Referral Source	CAP Agency Clinic	CARE Hosp	CPO Self	PCMAP Inter-Dept	SIDS Other

Date Received

Date Assigned:		Prev / Open	
Assigned by:		Assigned PHN:	

Print Form

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