KERN COUNTY
Public Health Services
DEPARTMENT

Perinatal Outreach Program (POP)

Referral

Date: _____

Name of Referral Party : _____Program/Agency: _____
Phone #: _____ Fax #: _____
Address: _____City: _____Zip Code: _____

Client Name: _____ DOB: _____
Address: _____ City: _____ Zip Code: _____
Mailing Address (if different): _____ City: _____ Zip Code: _____
Phone Number: _____ Cell Number: _____
Best Time to Contact: _____
Message Number / Contact Person: _____

EDC _____ G____ P____ Prenatal Care Provider _____
Race / Ethnicity _____ Language: _____
Medic-Cal (circle): Applied/Pending Not Applied Currently Receiving # _____

Has client been informed that she has been referred to POP?	YES	NO
Is this client's first time pregnancy?	YES	NO
If teen, can client be contacted by phone or mail?	YES	NO

Reason for Referral:

Medical Risks: _____
_____

High Risk Factors: _____
_____

FOR OFFICE USE ONLY

Date Referral Received: _____Date Entered to Insight: _____Insight # _____

Date Referral Assigned to Nurse: _____ Name of Nurse Assigned: _____

Additional Comments:_____

Maternal, Child and Adolescent Health Program
Phone: (661) 868-0524
FAX: (661) 868-1291