

COUNTY OF PLACER
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH

Office Use Only

S.T. # _____

Signed HIPAA on File:

 Yes No**PUBLIC HEALTH REFERRAL FORM**

Name: _____		Date of Referral: _____	
Birth Date: _____	Age: _____	To: _____	
Address: _____		In Home Support Svcs	General Nursing
City: _____		Teenage Parenting	
State: _____	Zip: _____	From: Agency: _____	
Home Phone: _____	Work Phone: _____	Person: _____	
Race: _____	Sex: _____	Address: _____	
Marital Status: Single Married		Phone: _____	
Language Spoken: _____		Client Notified of Referral: Yes No	
Physician's Name: _____		Physician's Phone Number: _____	
<u>Family Members</u>	<u>Birth Date</u>	<u>Relationship</u>	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Reason for Referral:

- | | | |
|--|--|---|
| <input type="checkbox"/> Education/Anticipatory Guidance | <input type="checkbox"/> Link to Durable Medical Equipment Resources | <input type="checkbox"/> Nursing Assessment |
| <input type="checkbox"/> Link to Resources/Services | <input type="checkbox"/> Safety/Fall Risk Assessment | <input type="checkbox"/> Teen Pregnancy/Parenting |
| <input type="checkbox"/> Link to Medical Provider | <input type="checkbox"/> Developmental Assessment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medical Certification | | |

County Use Only: (Notes)

Return this form by clicking the submit button in the upper right corner, or fax or mail:

Fax: 530-889-7198

Mail: Placer County Public Health

Attn: Nursing Referrals
11484 B Ave
Auburn, CA 95603