NN #_____

Referral Intake by_____

YOLO COUNTY HEALTH & HUMAN SERVICES AGENCY
HOME VISITING REFERRAL FORM

PROGRAM (circle one): Nurse Home Visiting | Adolescent Parenting Program | PHN Nurse Consult

*Date of Referral:	*Client Name: (First) (Last)
*Referred By:	*Birthdate:
Referral Response Requested ☐ No ☐ Yes	SS#: MC#:
*Agency:	*Address:
Phone: email:	
*Medical/Other Providers: Phone:	
	Phone: *H/M_____ W_____
Is client aware of referral: Y ☐ N ☐	Language:
Has the client been referred to other home visiting program: Y ☐ N ☐	
If yes, please specify:	Other client contact:
	*Phone:
	Relationship to client:

INFANT Full Name	M F	DOB:	Birth Wt:	Gest. Age:	Tox Status:	
MOB G___P___	SAB _____	TAB _____	Delivery Type: C-Section	NSVD	Tox Status:	

Reason for referral:

General medical concerns:

Prenatal concerns:

History of or current mental health issues:

Other referral reason, please circle:
CWS, CCS Patient, Parent Support, Teen Parent,
Other-

For Internal Use:

INSTRUCTIONS:

Fax this referral form to: 530-666-7447 (confidential) or E-mail a referral form to: raquel.aguilar@yolocounty.org

All areas with an * are required in order to fully set the client up and prevent delay in assigning client to their case manager.