Merced County Department of Public Health

Public Health Nursing Services Referral

Phone 1-800-649-6849 Fax 209-724-4011

Referring Agency and Provider Information			
Date of Referral:			
Name:		**Contact Person:**	
Address:	**Phone:**		**Fax:**

Reason for Referral			
First time Expectant Mother ☐	Teen 18 years or Less ☐	Psychosocial ☐	Postpartum ☐

Client Information			
Last Name:		**First Name:**	
Sex Male ☐ Female ☐		**Date of Birth:**	
Less than 18 Years: Consent to inform?	Yes ☐ No ☐		
Note: Provider is not permitted to inform a parent or legal guardian without the minor's consent.			
Address:	**City:**	**Zip Code:**	
Phone:	**Primary Language:**		
Speaks English Yes ☐ No ☐	**Race:**	**Hispanic** Yes ☐ No ☐	
Medi-Cal Yes ☐ No ☐	**Presumptive Eligibility** Yes ☐ No ☐		

Parent or Guardian Information		
Last Name:	**First Name:**	
Date of Birth:	**Phone:**	
Address:	**City:**	**Zip Code:**

Identified Infant Risk Factors		
Birth Weght:	Head Circumference:	
Apgars:	Discharge Weight:	
☐ SGA/IUG	☐ Premature Birth	
☐ Tox Screen Done	Tox Screen Results:	☐ Parent Refused Tox Screen
☐ Congenital Anomaly	☐ Persistent Respiratory Problems	☐ Persistent Feeding Problems
☐ Discharged on Monitor(s)	☐ Discharged on Medication(s)	
☐ CPS Referral or Involvement:		

Identified Antepartum and Postpartum Risk Factors			
EDC:	LMP:	☐ No or Late Prenatal Care	
☐ Drug use in Past 2 Years	Describe:		
☐ Risk for Postpartum Depression	*Score:*	*Scale:*	
☐ Medically High Risk / Delivery Complications	Describe:		
☐ Mental Health Diagnosis or on Medication(s)	Describe:		
☐ Uses Tobacco	☐ Questionable Bonding or Parenting	☐ Barriers to Learning	
☐ No Support System	☐ Limited Financial Resources	☐ Difficult Home Situation and or Abuse	
Pregnancy and Birth Information	Gravida:	Para:	
SAB:	TAB:	Living:	
Delivery Information	Vaginal:	Cesarean:	
Additional Comments:			