



Prenatal Referral Form for Alameda County Pacific Islander Case Coordination

For all referrals, please fax to 510.618.2077. Questions? Call 510.618.2079 or email: Milika.Funaki@acgov.org

Date _____ Referred by _____ Title _____

Referring Agency _____

Has the Provider shared this referral with the Patient? Y N Phone _____ Fax _____

CLIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Address # _____ St Name _____ Apt _____ City _____ Zip _____

Tel _____ Ethnicity _____ Language(s) Spoken _____

INSURANCE INFO: Alameda Alliance Blue Cross Medi-Cal Medi-Cal Other Health Insurance (please specify) _____

High-risk pregnancy? First Trimester (1-12wks) _____ Expected Date of Delivery: _____

Second Trimester (13-27wks) _____ Complications of pregnancy: _____

Third Trimester (28-40wks) _____

Prenatal Care Begun: date started _____ Prenatal Care Provider: _____

Additional Risk Factors? _____

For help enrolling in health insurance in Alameda County

- Does not need to be pregnant
- Help is free and confidential
- No need for immigration papers

First and Last Name	Phone Number	What city in Alameda County do you live in?	Do you have children that need insurance? How many?

*List additional names in the back