



Alameda County Health Care Services Agency

Public Health Nursing Referral Form

1100 San Leandro Blvd, San Leandro, CA 94577

Pre-Eligibility Unit: (510) 577-7080

FAX: (510) 383-5060 Alternate FAX: (510) 273-3962



REFERRAL SOURCE

Name:	Title:	Relationship/Agency/ School	Phone Number:	Fax Number:
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CLIENT INFORMATION

Last Name:	First Name	MI	Social Security #	Medi-Cal #	Date of Birth #
Current Address and City				Zip Code	Primary Language:
Home Phone #:	Cell Phone #:	Message Phone #:	Email Address:		
Medical Provider:	Insurance Provider:		EDD:		

PARENT/GUARDIAN (if client is a child)

Last Name:	First Name	MI	Social Security #	Medi-Cal #	Date of Birth	Primary Language
Current Address and City: (if different than client)				Zip Code	School Child(ren) Attend(s)	

Step 1: Population Category (please select only one category per referral):	Step 2: High Risk of Medical Compromise (Check one or more):
<input type="checkbox"/> Infant/Child (all criteria must be met)	<input type="checkbox"/> Fails to use health services
• Under the age of 21 years	<input type="checkbox"/> Noncompliance with medical regime
• High risk of medical compromise	<input type="checkbox"/> Inability to handle personal/medical affairs
(continue on to Steps 2, 3, & 4)	<input type="checkbox"/> Lacks coordination of medical/social services
<input type="checkbox"/> Medically Fragile (all criteria must be met)	<input type="checkbox"/> Lacks community support
• 18 years of age or older	<input type="checkbox"/> Comprehension/language barriers
• Multiple diagnoses (2 or more) please note in comments section	<input type="checkbox"/> Substance abuse
• High risk of medical compromise	<input type="checkbox"/> A victim of abuse/neglect/violence
(continue on to Steps 2, 3, & 4)	<input type="checkbox"/> other
<input type="checkbox"/> Institutional Risks (all criteria must be met)	Step 3: Assistance With / Linkage to Resources: (Check one or more)
• 18 years or older and in frail health	<input type="checkbox"/> Covered California / Medi-Cal / Health Insurance Applications
• Transitioning to community within 180 days	<input type="checkbox"/> Locating a Doctor / Dentist
• High risk of medical compromise	<input type="checkbox"/> Scheduling Appointments - Medical / Dental / Specialty Services
(continue on to Steps 2, 3, & 4)	Breastfeeding Support
<input type="checkbox"/> Communicable Disease (all criteria must be met)	<input type="checkbox"/> Childcare
• Infected or exposed to a communicable disease	<input type="checkbox"/> Counselors/Therapists
• High risk of medical compromise	<input type="checkbox"/> Educational Opportunities
(continue on to Steps 2, 3, & 4)	<input type="checkbox"/> Employment Opportunities
<input type="checkbox"/> Jeopardy of Negative Health or Psycho-Social Outcomes (Check one or more)	Food
<input type="checkbox"/> Substance abuse in the immediate environment	<input type="checkbox"/> Cash Assistance Applications
<input type="checkbox"/> Family violence, history of or in danger of	Housing
<input type="checkbox"/> Physical/sexual/emotional abuse, history of or in danger of	Immunizations/Vaccines
<input type="checkbox"/> Substandard housing, experiencing	Transportation
<input type="checkbox"/> Illiteracy	Utilities
(skip Step 2; continue on to Steps 3 & 4)	<input type="checkbox"/> Other _____

Step 4: Comments (Brief, detailed description / explanation of reason(s) for referral)

For Medically Fragile client referral, please list diagnoses below:

Diagnosis 1: _____ **Diagnosis 2:** _____

Referral Source- Please check if you want a return contact from the: Pre-Eligibility Unit Assigned Field Nurse or Outreach Staff

For ACPHD Use Only Date Referral Received: _____ Date Referral Given to Program: _____ Client aware of referral Yes No
Referred to: FHS PHN Older Adults Tattoo Removal Referral Source Contacted Yes No Date By

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