NN#:_____

# YOLO COUNTY HEALTH & HUMAN SERVICES AGENCY
# PUBLIC HEALTH REFERRAL

*Phone #: (530) 666-8688, Confidential FAX: (530) 666-7447*

| PROGRAM: FIMR/SUID/SIDS | |
|---|---|
| Date of Referral: | Parent's Name: |
| Referred By: | DOB: |
| Referral Response Requested: ☐Yes ☐No | SS# (opt): MC#: |
| Agency: | Address: |
| Phone: | |
| Email: | |
| Medical/Other Providers: Phone: | |
| | Phone: H/M W |
| | Email: |
| | Language: |
| | Other contact: Phone: |
| | Relationship of contact: |

INFANT: Full Name M ☐ F ☐ DOB: Birth Wt: Gest. Age: Tox Status:

MOB G___P___ SAB _____ TAB _____ Delivery Type: C-Section ☐ NSVD ☐ Tox Status:

Reasons for Referral: **Please attach any social work, nursing, OB Admission and/or discharge records if possible.**