YOLO COUNTY HEALTH & HUMAN SERVICES AGENCY
HOME VISITING REFERRAL FORM

NN #_____

Referral Intake by_____

PROGRAM: Choose one **Nurse Home Visiting (NHV)** **Adolescent Parenting Program (APP)**

***Date of Referral**:	***Parent/Caregiver**:(First) (Last)
***Referred By**:	***Birthdate**:
Referral Response Requested: Choose one	**MediCal # if known:**
***Agency**:	***Physical Address**:
Phone:	**Mailing Address:** Choose one **If different than above, add below.**
Email:	**Mailing Address:**
Medical/Other Providers:	**Email:**
Phone:	***Phone:** Choose one
Is client aware of referral: Choose one	**Other Phone:** Choose on
Has the client been referred to other home visiting program: Choose one	***Primary Language:** Choose one
	Other contact:
If yes, please choose one: Choose one	**Phone:**
	Relationship to client: Choose one
Other, please specify:	**Race:** Choose one

INFANT

Full Name: **Sex at birth:** Choose one **DOB:**

Birth Wt if known: **Gest. Age if known:** **Tox Status:** Choose one

MOB

G: **P:** **SAB:** **TAB:** **Delivery Type:** Choose one **Tox Status:** Unknown

***Reason for referral:**

Is individual being referred pregnant: Choose one **EDD:**

Prenatal concerns:

General medical concerns:

History of or current mental health issues:

Other referral reason:

For Internal Use:

INSTRUCTIONS:

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

All areas with an * are required in order prevent delay in assigning client to a case manager.

Updated: 1/19/2024