

PUBLIC HEALTH NURSING PROGRAMS REFERRAL

Call: 916-875-BABY

Fax: 916-875-0860

Email: DHSMCAH@saccounty.net



REFERRAL SOURCE:

Date:	Referred By:
Phone:	E-Mail:

FAMILY INFORMATION

Parent/Guardian:	Date of Birth:		
Address:	Male <input type="checkbox"/> Female <input type="checkbox"/> No Response <input type="checkbox"/>		
City:	Zip Code:		
Phone:	E-mail:		
Ethnicity: White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/>			
Mother Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/>	Due Date:	First Time Parent: Yes <input type="checkbox"/> No <input type="checkbox"/>	
List children age youngest to oldest:			
Child A:	Date of Birth:	Child D:	Date of Birth:
Child B:	Date of Birth:	Child E:	Date of Birth:
Child C:	Date of Birth:	Child F:	Date of Birth:

FAMILY NEEDS/ADDITIONAL INFORMATION

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I am aware my personal information may be shared with Sacramento County Maternal, Child & Adolescent Health Program for referral purposes.

Signature of Client: _____

☐ Client was verbally advised of referral

REFERRAL CRITERIA EXAMPLES (not all-inclusive)

	REFERRAL CRITERIA
<i>Pregnancy</i>	<ul style="list-style-type: none"> <input type="checkbox"/> First time mother. <input type="checkbox"/> Mother or father with limited support and/or infant care knowledge or first-time mom/parent. <input type="checkbox"/> Current substance misuse during pregnancy, substance misuse during pregnancy but has since stopped use, and/or substance misuse during previous pregnancies or within the last year. <input type="checkbox"/> History of maternal mental illness/developmental delays without treatment or services. <input type="checkbox"/> Maternal depression or history of post-partum depression. <input type="checkbox"/> Delivery with no or inadequate prenatal care. <input type="checkbox"/> History of abuse and/or neglect of other children. <input type="checkbox"/> Violence in home. <input type="checkbox"/> Physical symptoms/conditions that may complicate pregnancy: toxemia, preterm labor, severe nausea/vomiting, multiple gestation, gestational diabetes, severe anemia, inadequate or excessive weight gain, untreated or uncontrolled chronic illness.
<i>Children 0-18</i>	<ul style="list-style-type: none"> <input type="checkbox"/> Preterm infant born at or before 34 weeks. <input type="checkbox"/> Low birth weight (2,499 g/ 5 lbs. 8.1 ounces or less). <input type="checkbox"/> Prenatal drug exposure and/or a positive toxicological screen. This also includes substance-exposed children. <input type="checkbox"/> Infant appearing to have acute withdrawal symptoms. <input type="checkbox"/> Failure to thrive/feeding issues. <input type="checkbox"/> Maladaptive parent/infant interactions (refusing to feed, threatening infant/child, threatening to leave with infant AMA). <input type="checkbox"/> Newborn/infant who has physical or medical problems that may impact vital life functions including sustained hypoxia (lack of oxygen), pre or post-natal anomalies, or a life-threatening illness/condition such as respiratory distress syndrome. <input type="checkbox"/> Severe medical conditions not addressed by specialty care providers; needs linkages. <input type="checkbox"/> Child/Adolescent with developmental delays not addressed by specialty care providers; needs linkages. <input type="checkbox"/> Caretaker is medically non-compliant due to barriers in accessing care. <input type="checkbox"/> Caretaker has significant learning/developmental delays not addressed by intervention services. <input type="checkbox"/> Caretaker has a psychiatric disorder that puts the child at risk.
<i>At Risk Families</i>	<ul style="list-style-type: none"> <input type="checkbox"/> Infant or child under 18 years with possible developmental delays and not receiving early intervention services. <input type="checkbox"/> Parent/caregivers have unrealistic expectations or perceptions of infant/child's behavior or development; unresponsive to infant/child's needs and/ or needs specialized education regarding infant/childcare, nutrition, and/or safety issues. <input type="checkbox"/> Family has one or more barriers to accessing basic needs, including: community resources, insurance, health care providers. <input type="checkbox"/> Family has challenges in following through with appointments and/or health provider recommendations. <input type="checkbox"/> One or more household members engage in at-risk behaviors including: substance misuse, gang involvement, violent behaviors, and/or unprotected sex. <input type="checkbox"/> Potential for or history of domestic or intimate partner violence. <input type="checkbox"/> Unstable housing. <input type="checkbox"/> Five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence. <input type="checkbox"/> Three or more hospital stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence. <input type="checkbox"/> Family has minimal coping or problem-solving skills. <input type="checkbox"/> Family does not have an identifiable support network.

For Internal Use- Notes: