

ADOLESCENT FAMILY LIFE PROGRAM REFERRAL FORM

VENTURA COUNTY PUBLIC HEALTH

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 OXNARD, CA 93036
 PHONE: (805) 981 5177
 FAX: (805) 981 5260
 BROWN MAIL # 4612

ELIGIBILITY REQUIREMENTS:
 FEMALES: PREGNANT/ PARENTING TEENS (18 OR UNDER)
 MALES: 18 OR UNDER & INVOLVED WITH PREGNANCY AND/OR INFANT

THIS INFORMATION IS INTENDED ONLY FOR THE USE OF THE AFLP OFFICE. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE DELIVER IT TO THE INTENDED RECIPIENT. DISCLOSURE, COPYING, DISSEMINATION OR THE TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TRANSMITTED INFORMATION IS STRICTLY PROHIBITED.

AFTER YOU COMPLETE REFERRAL, PLEASE EITHER FAX OR SEND BY BROWN MAIL.

REFERENT'S NAME		AGENCY :		PHONE NUMBER :	
REFERENT'S STREET, CITY AND ZIP		CAN WE FAX REFERRAL DISPOSITION TO YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		FAX NUMBER :	
CLIENT NAME:		LANGUAGE :	D.O.B:	AGE:	SEX: MARITAL STATUS :
STREET, CITY AND ZIP				HOME/ MESSAGE PHONE :	
RESIDES WITH:		RELATIONSHIP:		LANGUAGE:	
ATTENDING SCHOOL: <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF SCHOOL ATTENDING/LAST ATTENDED:			GRADE:	
MEDICAL NUMBER:		CLIENT RECEIVING CAL WORKS: <input type="checkbox"/> YES <input type="checkbox"/> NO		PRENATAL CARE : <input type="checkbox"/> YES <input type="checkbox"/> NO	
CLIENT AWARE OF REFERRAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	O.K. TO CONTACT CLIENT AT HOME: <input type="checkbox"/> YES <input type="checkbox"/> NO				

REASON(S) FOR REFERRAL:	CHECK (✓) ALL THAT APPLY
<input type="checkbox"/> Home Assessment <input type="checkbox"/> Infant/child <input type="checkbox"/> Safety Assessment <input type="checkbox"/> Asthma <input type="checkbox"/> Nutrition <input type="checkbox"/> COPD <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Anemia <input type="checkbox"/> Post Partum <input type="checkbox"/> Diabetes <input type="checkbox"/> Other: _____	<input type="checkbox"/> Obesity <input type="checkbox"/> Teen Parent/Pregnancy (DOB / EDC()) <input type="checkbox"/> Breastfeeding Assessment <input type="checkbox"/> Chronic/Condition/Disease: _____ <input type="checkbox"/> Non-Adherence: _____

Comments:

AGENCIES NOW INVOLVED WITH CLIENT:

1}	2}
3}	4}

DATE:	SIGNATURE
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FOR AFLP/PHN USE ONLY

REPORT BACK TO REFERRAL SOURCE: <input type="checkbox"/> NO FOLLOW UP <input type="checkbox"/> CLIENT REFUSAL <input type="checkbox"/> UNABLE TO LOCATE <input type="checkbox"/> NO SUCH ADDRESS