



PERINATAL SUBSTANCE ABUSE SERVICES INITIATIVE
Assessment & Coordination Team (ACT) (714) 834-7900

SERVICE REFERRAL:
COMPLETE AND RETURN
FAX: (714) 834-7977

SERVICE REFERRAL

Ref Date: _____ Source: _____ Ph: _____
Name and Program of Referring Party

CLIENT NAME _____ DOB: _____ LANG _____
Last First M.

Type	ADDRESS	APT	CITY	ZIP	TELEPHONE
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*Type of Residence: 1-Perm./Stable Residence 2-Motel 3-Shelter 4-Temp. Residence 5-Residential Treatment Program 6-Homeless 7-Jail

EMERGENCY CONTACTS:

RELATIONSHIP	NAME	ADDRESS	TELEPHONE

DEMOGRAPHIC DATA:

Race/Ethnicity _____ Marital Status: Single [] Married [] Divorced [] Separated [] Other []

Monthly Income \$ _____ Source: Employment [] Cash Aid [] SSI [] Unemployment/Disability [] GR [] Other

Medical Coverage:	1 -Restricted/ Straight Medi-Cal 4-Medi-Cal Pending	2 -CalOPTIMA HP _____ 5-Needs to apply for Medi-Cal	3 -Private Ins /Cash Pay PE- Presumptive Eligibility
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OB HISTORY: G _____ P _____ TAB _____ SAB _____ LC _____ LMP _____ GA _____ **EDC** _____

Complications or Problem _____

* Needs prenatal care [] Under Prenatal care [] Please give date or GA when care started _____

Doctor's Name _____ Phone _____ # of Visit to date _____

Drug Use Hx: _____

_____ Last Stated Use: _____

Alcohol use? Y [] N [] Alcohol use this pregnancy? Y [] N [] Tobacco use? Y [] N [] 2nd hand smoke? Y [] N []

Current drug treatment program _____

Psycho/Social Hx: _____

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