SUBMIT BY EMAIL PRINT

PERINATAL SUBSTANCE ABUSE SERVICES INITIATIVE
Assessment & **C**oordination **T**eam (**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
					( )
					( )

***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 ☐**2**-CalOPTIMA HP_____ ☐**3**-Private Ins /Cash Pay
☐4-Medi-Cal Pending ☐5-Needs to apply for Medi-Cal PE- Presumptive Eligibility

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: _____

_____

_____