County of Orange, CA Health Care Agency
Public Health Community Nursing

REFERRAL FORM - CHAT-H

Referral Date: _____
Fax attention to: Becky Stone, SPHN
(714) 834-7977

Language: _____

Referring Source: _____
Agency Contact Person Phone # Fax #

Client Address/Location: _____
(Motel/Shelter Name) Street Apt/ Room # City Zip

Phone: Cell (____) _____ Home (____)_____ Motel (____)_____ Emergency (____)_____

Client's Legal name: **Health insurance coverage: (please indicate health problems below)**

1. _____ ❑ M ❑ F ❑ None ❑ Medi-Cal Doctor: ❑ Y ❑ N
Name DOB

Family Members:

2. _____ ❑ M ❑ F ❑ None ❑ Medi-Cal Doctor: ❑ Y ❑ N
Name DOB

3. _____ ❑ M ❑ F ❑ None ❑ Medi-Cal Doctor: ❑ Y ❑ N
Name DOB

4. _____ ❑ M ❑ F ❑ None ❑ Medi-Cal Doctor: ❑ Y ❑ N
Name DOB

5. _____ ❑ M ❑ F ❑ None ❑ Medi-Cal Doctor: ❑ Y ❑ N
Name DOB

6. _____ ❑ M ❑ F ❑ None ❑ Medi-Cal Doctor: ❑ Y ❑ N
Name DOB

7. _____ ❑ M ❑ F ❑ None ❑ Medi-Cal Doctor: ❑ Y ❑ N
Name DOB

Health Needs (Identify who has what needs by number(s) above):

❑ Needs assistance with insurance (Medi-Cal, etc.)_____

❑ Needs medical care for urgent problem _____

❑ Has a doctor-diagnosed medical problem or Chronic Illness: _____

❑ Is anyone behind on Immunizations?_____ ❑ Does anyone have a disability:_____

❑ History Drug/Alcohol Use_____ ❑ History/Current Emotional/Physical Abuse _____

❑ History/Current Depression_____ ❑ Mental Health problem/diagnosis _____

❑ Dental need(s):_____ ❑ Vision need(s): _____

❑ Other_____

Additional Information:

Other agencies/professionals providing services:_____