Tuolumne County Public Health Department
Referral Form

Referral date:

REFERRING AGENCY INFORMATION

Agency name:_____ **Form completed by**:_____

Phone number:_____ **Referral follow up requested**: Yes ☐ No ☐

CLIENT INFORMATION

Legal name:_____ **Name used** (if different):_____

DOB:_____ **Is client aware of referral?** Yes ☐ No ☐

Pronouns (if known): She/Her ☐ He/Him ☐ Other_____

Preferred language: English ☐ Spanish ☐ Other:_____

Insurance: Medi-Cal ☐ Medicare ☐ Private ☐ None ☐ Unknown ☐

Phone number: _____ **May we leave a voice-mail:** Yes ☐ No ☐ **May we send a text:** Yes ☐ No ☐

Physical address: _____

Mailing address (if different from above):_____

Legal parent/guardian name:_____ n/a ☐ **Relationship to client**:_____ n/a ☐

Additional family/household dynamic information:_____

_____

Best day/time to contact:_____

REFERRED TO (check all that apply)

Descriptions of programs available at https://www.tuolumnecounty.ca.gov/250/Public-Health

WIC ☐ ASQ-SE II ☐ Oral Health ☐ Child Passenger Safety ☐ Immunization Clinic ☐
Home Visiting ☐ Maternal, Child, Adolescent Health Program (MCAH) ☐ California Children's Services ☐
Foster Care Nurse ☐ Child Health & Disability Prevention (CHDP) ☐ CWS/APS Nurse ☐ Tobacco Control ☐
LICN Mobile Health Van ☐ Lead Poisoning Prevention ☐ Other:_____

DESCRIBE REASON FOR REFERRAL/REQUESTED SERVICES

Submit form via email to health@tuolumnecounty.ca.gov or fax 209-533-7406.

THIS PAGE IS TO BE COMPLETED BY TUOLUMNE COUNTY PUBLIC HEALTH DEPARTMENT PERSONNEL ONLY

Date referral received:_____

REPORT OF FOLLOW UP

Follow up completed by: Program name_____

Outcome: Opened ☐ Already open ☐ Unable to locate ☐ Declined services ☐

CHART NOTES

Include contact attempts or services provided, and personnel name.

Date:	Notes:

Date closed: _____ Reason for closing:_____

Final outcome: _____