Case Management Referral

Community Health Services
Stanislaus County Health Services Agency
830 Scenic Drive, Building 3
Email: PHN-CHS@schsa.org
Phone: (209) 558-7400 / Fax: (209) 558-8315

Office Use Only
Parent ECM:_______________
Child ECM:_______________

REFERRING AGENCY / INDIVIDUAL		
Referring Agency/Individual:		
Address:	City:	Zip:
Phone:	Cell Phone:	Fax:
Email:	Reply Requested: Yes: No:	

PARENT(S) / CAREGIVER	
Name:	DOB:
Medi-Cal/CIN #:	SSN#:

CHILD / CHILDREN	
Child's Name:	DOB:
Medi-Cal/CIN #:	SSN#:
Additional Children Name(s):	DOB:
Medi-Cal/CIN #:	SSN#:

CLIENT CONTACT INFORMATION		
Home Address:	City:	Zip:
Additional Address:	City:	Zip:
Phone:	Alt. Phone:	
Language:	Ethnicity:	

CONCERN / HEALTH ISSUES / PRIMARY REASON FOR REFERRAL:

Records/Discharge Summary Sent? Yes: No: **Client Knows of Referral?** Yes: No:

Pregnant Parenting	Infant / Child	Agencies Referred
Due Date:_____________ G________ P_______	BW__________ BL__________ BHC__________	CCS Referred / Open:___________________
First Baby? Yes No	Current weight:_________________________	CPS Referred / Open:___________________
Prenatal Care Provider:___________________	Gestational age:_________________________	SSI Referred / Open: ___________________
Entered Prenatal Care: Yes No	Discharge date:_________________________	VMRC Referred / Open:_________________
Tox screen results:_______________________	Tox screen:_____________________________	WIC Referred / Open:___________________
Substance:______________________________	Substance:______________________________	School:__________________________
Parent of teen Knows?___________________	Peds. Provider:___________________________	Grade:___________________________
# of children in home:____________________	Last seen:__________ Next appt.:__________	Attending: Yes No
	Breast or Bottle fed:______________________	
	Type of Formula:_________________________	

SIGNATURE / DATE

	Office Use Only
	Program:_________________________________
SIGNATURE:_________________________________	Date:_________________________________
DATE:_________________________________	Case Manager:_________________________________

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