Submit Form

COUNTY OF PLACER
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH

Office Use Only
S.T. # _____
Signed HIPAA on File:
☐ Yes ☐ No

PUBLIC HEALTH REFERRAL FORM

Name: _____
Birth Date: _____ **Age:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____
Race: _____ **Sex:** ☐
Marital Status: ☐ Single ☐ Married
Language Spoken: _____
Physician's Name: _____

Date of Referral: _____
To: _____
☐ **In Home Support Svcs** ☐ **General Nursing** ☐ **Teenage Parenting**
From: Agency: _____
Person: _____
Address: _____
Phone: _____
Client Notified of Referral: ☐ Yes ☐ No
Physician's Phone Number: _____

Family Members	**Birth Date**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for Referral:

☐ Education/Anticipatory Guidance
☐ Link to Resources/Services
☐ Link to Medical Provider
☐ Medical Certification
☐ Link to Durable Medical Equipment Resources
☐ Safety/Fall Risk Assessment
☐ Developmental Assessment
☐ Nursing Assessment
☐ Teen Pregnancy/Parenting
☐ Other: _____

County Use Only: (Notes)

Return this form by clicking the submit button in the upper right corner, or fax or mail:

Fax: 530-889-7160

Mail: Placer County Public Health
Attn: Nursing Referrals
11572 B Avenue
Auburn, CA 95603

(Rev. 9-18)