



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:
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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

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