Clear Data

ADOLESCENT FAMILY LIFE PROGRAM REFERRAL FORM

SUBMIT HERE

VENTURA COUNTY PUBLIC HEALTH

1701 SOLAR DR., SUITE 260
OXNARD, CA 93036
PHONE: (805) 981 5177
FAX: (805) 981 5260
BROWN MAIL # 3781

ELIGIBILITY REQUIREMENTS:
FEMALES: PREGNANT/ PARENTING YOUTH (21 OR UNDER)
MALES: 21 OR UNDER & INVOLVED WITH PREGNANCY AND/OR INFANT

THIS REFERRAL FORM MAY BE SENT VIA E-MAIL TO AFLP@VENTURA.ORG

AFTER YOU COMPLETE REFERRAL, PLEASE EITHER FAX OR SEND BY BROWN MAIL.

REFERENT'S NAME	AGENCY :	PHONE NUMBER :
REFERENT'S STREET, CITY AND ZIP	CAN WE FAX REFERRAL DISPOSITION TO YOU? ☐ YES ☐ NO	FAX NUMBER :

CLIENT NAME:	LANGUAGE :	D.O.B:	AGE:	SEX:	MARITAL STATUS :

STREET, CITY AND ZIP	HOME/ MESSAGE PHONE :

RESIDES WITH:	RELATIONSHIP:	LANGUAGE:

ATTENDING SCHOOL: ☐ YES ☐ NO	NAME OF SCHOOL ATTENDING/LAST ATTENDED:	GRADE:

MEDICAL NUMBER:	CLIENT RECEIVING CAL WORKS: ☐ YES ☐ NO	PRENATAL CARE : ☐ YES ☐ NO

CLIENT AWARE OF REFERRAL: ☐ YES ☐ NO	O.K. TO CONTACT CLIENT AT HOME: ☐ YES ☐ NO

REASON(S) FOR REFERRAL: CHECK (✓) ALL THAT APPLY

☐ Home Assessment	☐ Infant/child	☐ Obesity
☐ Safety Assessment	☐ Asthma	☐ Teen Parent/Pregnancy (DOB / EDC( )
☐ Nutrition	☐ COPD	☐ Breastfeeding Assessment
☐ Prenatal Care	☐ Anemia	☐ Chronic/Condition/Disease:_____
☐ Post Partum	☐ Diabetes	☐ Non-Adherence: _____

☐ Other: _____

Comments:

AGENCIES NOW INVOLVED WITH CLIENT:

1}	2}
3}	4}

DATE:	SIGNATURE

FOR AFLP/PHN USE ONLY

REPORT BACK TO REFERRAL SOURCE: ☐ NO FOLLOW UP ☐ CLIENT REFUSAL ☐ UNABLE TO LOCATE ☐ NO SUCH ADDRESS