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OC Health Care Agency Public Health
PERINATAL SUBSTANCE ABUSE SERVICES INITIATIVE
Assessment & **C**oordination **T**eam (**ACT**) **(714) 704-8581**
SERVICE REFERRAL/FACE SHEET

SERVICE REFERRAL:
COMPLETE AND RETURN
FAX: (714) 480-4616

*Ref Date:*_____ *Source:* _____ *Ph:* _____
Name and Program of Referring Party

CLIENT NAME_____ DOB: _____ LANG_____
Last First M.

SS#: _____ UCI PF # _____

Type	ADDRESS	APT	CITY	ZIP	TELEPHONE

***Type Of Residence**: 1-Perm./stable residence 2-Motel 3-Shelter 4-Temp. Residence 5-Residential Tx Prog 6-Homeless (street/car) 7-Detention facility

EMERGENCY CONTACTS:

RELATIONSHIP	NAME	ADDRESS	TELEPHONE

DEMOGRAPHIC DATA:

Race/Ethnicity _____Marital Status: S[ ] M[ ] D[ ] Sep[ ] W[ ]

Monthly Income $_____Source: Employment [ ] AFDC [ ] SSI[ ] Unemployment/Disability[ ] GR[ ] Other _____

Medical Coverage: **1**-Restricted/ Straight Medi-Cal **2**-CalOPTIMA HP_____ **3**-Private Ins / AIM / Cash Pay
4-Medi-Cal Pending 5-Needs to apply for Medi-Cal PE- Presumptive Eligibility

OB HISTORY: G _____ P _____ TAB _____ SAB _____ LC _____ LMP _____ GA _____EDC_____
Complications or Problem _____

*** Needs prenatal care [ ] Is under Prenatal care [ ] Please give date or GA when care started** _____
Doctor's Name _____ **Phone** _____**# of Visit to date** _____
Drug Use Hx: _____
_____
_____ Last Stated Use: _____

Alcohol use? Y [ ] N [ ] Alcohol use this pregnancy? Y [ ] N [ ] Tobacco use? Y [ ] N [ ] 2nd hand smoke? Y [ ] N [ ]

Current drug treatment program _____
Psycho/Social Hx: _____
_____
_____
_____

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