County of Orange, CA Health Care Agency
Public Health Community Nursing

REFERRAL FORM - CHAT-H

Referral Date: _____
Fax attention to: Becky Stone, SPHN
(714) 834-7977

Referring Source:_____
Agency Contact Person Phone # Fax #

Client Address/Location: _____
(Motel/Shelter Name) Street Apt/ Room # City Zip

Phone Numbers: Cell #: (___) _____ Home # (___) _____ Motel # (___) _____ Emergency #: (___) _____

Family Members: *Agency Code*: _____ **Health insurance coverage:**

1._____ ❑ M ❑ F ❑ None ❑ Medi-Cal/Health Plan:_____Problem _____
Name DOB

2._____ ❑ M ❑ F ❑ None ❑ Medi-Cal/Health Plan:_____ Problem _____
Name DOB

3._____ ❑ M ❑ F ❑ None ❑ Medi-Cal/Health Plan:_____ Problem _____
Name DOB

4._____ ❑ M ❑ F ❑ None ❑ Medi-Cal/Health Plan:_____ Problem _____
Name DOB

5._____ ❑ M ❑ F ❑ None ❑ Medi-Cal/Health Plan:_____ Problem _____
Name DOB

6._____ ❑ M ❑ F ❑ None ❑ Medi-Cal/Health Plan:_____ Problem _____
Name DOB

7._____ ❑ M ❑ F ❑ None ❑ Medi-Cal/Health Plan:_____ Problem _____
Name DOB

Medical Home (Identify individual(s) by number):

Does not have a doctor/clinic to go to if needed: _____

Is behind on Immunizations: _____

Health Needs (Identify individual(s) by number):

❑ Needs assistance with insurance (Medi-Cal, MSI, etc.)_____ ❑Disability:_____

❑ Needs medical care for urgent problem _____

❑ Has a doctor-diagnosed medical problem

❑Diabetes_____ ❑High Blood Pressure/Heart Issues_____ ❑Asthma_____ ❑Other: _____

"Are you taking prescribed medications?" "How often do you see a doctor for this?" "Do you believe this condition is under good control?"

_____Needs assistance with:_____

❑ History Drug/Alcohol Use_____ ❑ History/Current Emotional/Physical Abuse _____

❑ History/Current Depression_____ ❑ Mental Health problem/diagnosis _____

❑ Dental need(s):_____ ❑ Vision need(s):_____

❑ Other_____

Additional Information (Identify individual(s) by number):

Other agencies/professionals providing services:_____

_____