Santa Clara County Black Infant Health Program
Client Referral Form

E-mail completed forms to: Ebony.gross@phd.sccgov.org

Fax: (408) 937-2272 *Phone*: (408) 937-2492 *Date:*

***Referral Source:* (please circle one)**

☐ Social Services ☐ Medical Provider ☐ Returning Client ☐ Self ☐ Other Agency

(Please specify): ____

Contact Person (Phone #): ______________________________________

Client Information:

Name: *Date of Birth:*

Address:

Zip Code: *Phone Number:*

Estimated due date (if known)*:*

Please check all that apply to the woman being referred:

☐ Currently pregnant
☐ **How far long in the pregnancy?______**weeks
☐African/African American Descent
☐ At least 16 years of age
☐ Has access to technology for telehealthcommunications if needed?

Additional Information

PHN assigned: ______________________ **Enrolled: Yes☐ No ☐**
F/U Date: __________________________ **Visit scheduled: Yes ☐ No ☐**