Santa Clara County Black Infant Health Program

Client Referral Form

Attention: Beverley White-Macklin E-mail: Beverley.White@phd.sccgov.org

Fax: (408) 937-2291 Phone: (408) 937-2270 Date: ______________________

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

Social Services Medical Provider Returning client Self other

Agency (Please specify):____

Contact Person (email/Phone #):____

Client Information:

Name: ____________________________________ *Date of Birth:* ___/___/_____

Address: ______________________________

Zip Code: ______________ *Phone Number:*__________________________________

Estimated due date: ____/____/______

Please check all that apply to the woman being referred:

- ☐ Currently pregnant 30 weeks or less
- ☐ African/African American descent
- ☐ At least 18 years of age

Additional Information:

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(For Agency Use Only)

PHN response: ☐ **Client Not Found** ☐ **Client Refused services** ☐ **Client enrolled**

F/U Date:________________ Visit Scheduled: Yes ☐ No ☐