



CITY OF LONG BEACH
DEPARTMENT OF HEALTH AND HUMAN SERVICES

**Public Health Nursing
Referral**

Referral Date

NAME(S) OF CHILD(REN) OR INDIVIDUAL(S) BEING REFERRED _____
DATE OF BIRTH: _____
MEDI-CAL/SS#: _____

IF CHILDREN:
MOTHER'S NAME: _____ FATHER'S NAME: _____

ADDRESS:		PHONE #	
PRIMARY LANGUAGE:	Message Contact Person / Phone #:		
REFERRED BY:	PHONE #:	E-MAIL:	

(NAME & AGENCY)

[] CHECK HERE IF YOU WOULD LIKE TO BE CONTACTED BY THE PHN REGARDING THIS REFERRAL

THIS FAMILY/INDIVIDUAL HAS ALSO BEEN REFERRED TO:
(e.g. DEPT OF CHILDREN AND FAMILY SERVICES, ADULT PROTECTIVE SERVICES, ENVIRONMENTAL HEALTH, etc.)

AGENCY: _____ CONTACT PERSON: _____ PHONE #: _____

AGENCY: _____ CONTACT PERSON: _____ PHONE #: _____

REASON FOR PHN REFERRAL: (Details needed, please include: medical/health issues, mental health issues, medication, psych/social issues).
(ATTACH ADDITIONAL PAGE IF NECESSARY)

FAX THIS REFERRAL TO:(562) 570-4099
To confirm receipt of fax call Gloria Vivero at 562-570-4210

IF ANY QUESTIONS PLEASE CALL PHN Eileen Margolis: (562) 570-4272
or Pam Shaw, Nursing Services Officer (562) 570-4208

FOR OFFICE USE ONLY

RECORD SEARCH BY: _____ CT _____ DT _____ NEW _____ RET _____

RECORD# _____ REFERRAL TAKEN BY: _____

ASSIGNED PHN: _____ DATE _____