Referral for Kern County
NFP Services

Date of Referral:

Nurse-Family Partnership
Helping First-Time Parents Succeed

PHONE: Bakersfield (661) 868-5260 East Kern: (760) 375-5157 FAX: (661) 393-3159

Referring party: _____ Agency: _____
Your name Title

Address: _____ _____ _____
(Telephone Number) (FAX Number)

Client is aware of Referral: Y or N

CLIENT INFORMATION

COMPLETE INFORMATION ENSURES PRIORITY SERVICE FOR YOUR CLIENT

Client Name: _____ DOB: _____ Age: _____

Address: _____
Street Apt. City State Zip

Mailing Address if Different: _____

Telephone #: _____ Message #: _____

Client's Language: _____ Home Language: _____

Marital Status: _____ Client Resides With: _____

Other Referrals Made: (POP, AFLP, BIH): _____

Other Agencies involved (circle): Probation, Kern Regional Center, Cal Works/Learn, WIC, KMH, Kern Linkage, AFLP,

Other: (please list):_____

Prenatal Care (circle) Y or N (If yes, specify clinic/MD): _____

Type of insurance (Emergency Medi-Cal, Medi-Cal, presumptive eligibility, Kaiser, Health Net, other): _____

Medi-Cal # _____ issue date: _____

EDC: _____ Type of Pregnancy: Single or Multiple G (# of this preg): _____ P (# of live births): _____

Is Family/Parent Aware of Pregnancy? Y or N _____ Is Father of Baby Involved? Y or N _____

List any Medical Complications or Pre-Existing Health Conditions: _____

History of Abuse? (check all that apply): Drug ___; Sexual ___; Domestic ___; Mental ____; Physical ____; Other (specify)___

Psychosocial Issues? (or other services Client is receiving): _____

Education/Special needs?: _____ If school age: Enrolled? Y or N Grade level: _____

Other Comments for priority consideration:_____

NFP Use Only

1. Enrolled in NFP 2. Refused participation in program 3. Unable to locate 4. Did not meet program criteria 5. Program full

PHN Notes:

A _____
GA _____
I _____
MC _____
PS _____
Ab _____
E/SN _____
P _____
= ____ / 16
PRIORITY
_____