KERN COUNTY PUBLIC HEALTH
Grounded in Health

Perinatal Outreach Program (POP) Referral

Date: _____

Referring Party: _____Program/Agency: _____
Phone #: _____ Fax #: _____
Address: _____City: _____Zip Code: _____

Client Name: _____DOB: __/__/____ Mother's First Name_____
Address: _____ City: _____ Zip Code: _____
Mailing Address (if different): _____ City: _____ Zip Code: _____
Phone Number: _____ Cell Number: _____
Best Time to Contact: _____ Email:_____
Message Number / Contact Person: _____

EDC _____ G____ P____ Prenatal Care Provider _____
Race / Ethnicity _____ Language _____
Medic-Cal (circle): __ Applied/Pending ___Not Applied ___Currently Receiving # _____

Has client been informed that she has been referred to POP? YES NO
Is this client's first pregnancy? YES NO
If teen, can client be contacted? No___ or Yes ___ method ____Phone and/or ____Mail

Reason for Referral:

Medical Risks: _____
_____
High Risk Factors: _____
_____

FOR OFFICE USE ONLY

Date Referral Received: _____Date Entered into Insight: _____Insight # _____

Date Referral Assigned to Staff: _____ Name of Staff Assigned: _____

Please Fax Referral to - FAX: (661) 868-1291