KERN COUNTY PUBLIC HEALTH SERVICES DEPARTMENT

Maternal, Child and Adolescent Health
1800 Mt. Vernon Avenue, 2nd floor
Bakersfield, CA 93306
Phone (661) 321-3000 Fax (661) 868-1291

BLACK INFANT HEALTH
Referral Form

[PART I – To Be Completed By Referring Individual / Agency]

Client Name: ____ DOB: _________________________________

Client's Mother's First Name: _________________________________

Address: ____ Zip Code: _____________________________

Telephone Number: ____ Message Number: ____________________

EDC _______________ G/P _______ Care Site: ____

Medical Insurance Provider: ____

Referring Agency: ____ Title: ___________________________

Name of Referrer: ____ Contact Number: ______________________

☐ Client is informed that she is being referred to BIH Services

☐ Client has received information about BIH Services Date: __________________

Any Immediate Concerns:____

[PART II – To Be Completed By Kern County Public Health – BIH Staff]

FOLLOW-UP: **ETO Case Number:** _______________

☐ Client accepted BIH Services Date: ____________________________________

☐ Client declined BIH Services Date: ____________________________________

☐ Client referred to: _________________________ Date: ____________________________________

☐ Client Enrolled Date: ____________________________________

☐ Client Scheduled Intake Date: ____________________________________

☐ Unable to Contact Date: ____________________________________

Client Contact Letter Mailed ☐ Yes ☐ No Date: ____________________________________

FHA Assigned: ___________________________________ Date: ____________________________________

Please fax completed form to the BIH office at (661) 868-1291 within 72 hours