

MCAH USE ONLY
MIS # _____

FRESNO COUNTY, DEPARTMENT OF COMMUNITY HEALTH
COMPREHENSIVE PERINATAL SERVICES PROGRAM
MATERNAL, CHILD, & ADOLESCENT HEALTH (MCAH)
PRENATAL PATIENT REFERRAL

INDEXING/AVATAR
USE ONLY
CT - _____

Date: _____

To: <input type="checkbox"/> MCAH (Attn: Public Health Nurse) (Fax # 559-445-3560)	From: _____ (agency/provider and name of contact person)
Reply Requested _____	_____ (phone) _____ (fax)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Person _____
CPSP Provider <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Information

Name (Last, First) _____ **Date of Birth** _____

Address _____ **Phone:** _____ **Msg:** _____

City/Zip _____ **Spouse or Parent's name** _____

If client is under age 18, are parents aware of the pregnancy? Yes No Unknown

Medi-Cal Yes No **Presumptive Eligibility** Yes No

Other Insurance? **If YES:** _____

Ethnicity _____ **Language (primary)** _____ **Speaks English** Yes No

<u>Patient's Perinatal History</u>	<u>Patient's Other History</u>
Month of Pregnancy entered PNC – 1 2 3 4 5 6 7 8 9 No Care EDC _____ LMP _____ G _____ P _____ SAB _____ TAB _____ Living _____	4P's + done? <input type="checkbox"/> Yes <input type="checkbox"/> No Positive? <input type="checkbox"/> Yes <input type="checkbox"/> No Follow up questions positive? <input type="checkbox"/> Yes <input type="checkbox"/> No Self-disclosure <input type="checkbox"/> Yes <input type="checkbox"/> No Pre-tx provided? <input type="checkbox"/> Yes <input type="checkbox"/> No Referred to treatment provider? <input type="checkbox"/> Yes <input type="checkbox"/> No Program _____ Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No Around smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
List other risks/problems/barriers to PNC _____ _____	

I authorize the release of the above information to Fresno County Department of Community Health, Maternal, Child and Adolescent Health, and if a teenager to Cal-Learn/AFLP to assist me in obtaining needed services for the issues referenced above. I also authorize MCAH to provide information regarding services provided to my OB/GYN provider.

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Disposition Date: _____ By: _____

- | | |
|---|--|
| <input type="checkbox"/> CC Monitor | <input type="checkbox"/> CC Monitor Waiting List |
| <input type="checkbox"/> Nurse Family Partnership | <input type="checkbox"/> NFP Waiting List |
| <input type="checkbox"/> Case Management-Brix | <input type="checkbox"/> CCM Waiting List |
| <input type="checkbox"/> Case Management-WF | <input type="checkbox"/> Info/Referral |
| <input type="checkbox"/> Cal Learn/AFLP | |
| <input type="checkbox"/> Not Eligible (No Action Taken-No MIS/Avatar Entry) | |

Patient's Signature

Date

Witness

