

County of San Bernardino
 DEPARTMENT OF PUBLIC HEALTH
 Maternal, Child and Adolescent Health Section
BLACK INFANT HEALTH REFERRAL FORM

REFERRAL SOURCE INFORMATION

Referral Date: _____
MM/DD/YYYY

Agency Referral
 Agency Name: _____

Client/Self Referral
 Other Referral Source

Agency Phone # _____
area code and number

Agency Fax # _____
area code and number

CLIENT INFORMATION

First Name: _____ **Last Name:** _____

Address: _____ **Apt #** _____

City: _____ **Zip Code*:** _____
*Target zip codes at bottom of Page 2

Date of Birth: _____
MM/DD/YYYY

Age: _____
Client must be 18 years old at time of referral

Maiden Name/AKA: _____

Race:
 African American or Black

Ethnicity:
 Non-Hispanic

Type of Health Insurance:
 Medi-Cal
 MediCare
 Private Insurance/Self Pay
 M/C Fee for Service
 Other Government
 No Health Insurance

Home Phone: _____
area code and number

Message Phone: _____
area code and number

Staff Area Only

Medi-Cal Eligible:
 1. Yes
 2. No

Medi-Cal Number: _____

P.E. Number: _____

Medi-Cal Aid Code: _____

PREGNANCY/ DELIVERY HISTORY

Pregnancy Status:
 Pregnant
 Pregnant and Parenting

Client at Risk:
 No
 Yes (specify) _____

LMP: _____
MM/DD/YYYY

Notes: _____

EDC: _____
MM/DD/YYYY

BLACK INFANT HEALTH CONTACT INFORMATION

ADDRESS: 505 N ARROWHEAD AVE, 3RD FLOOR, SAN BERNARDINO, CA 92415-0028

TELEPHONE: 1-800-227-3034 **REFERRAL FAX NUMBER:** (909)-388-5760

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REFERRAL INFORMATION (cont)

CLIENT NAME: _____

PREGNANCY/ DELIVERY HISTORY (continued)

Pregnancy History - Notes _____

SERVICES REFERRED

- | | |
|--|--|
| <input type="radio"/> Black Infant Health (BIH) | <input type="radio"/> Pediatrician |
| <input type="radio"/> Maternal, Child and Adolescent Health Clinic | <input type="radio"/> Reproductive Health |
| <input type="radio"/> Smoking Cessation | <input type="radio"/> Other (specify): _____ |
| <input type="radio"/> Parenting | |
| <input type="radio"/> Pregnancy Counseling | |
| <input type="radio"/> Substance Abuse Cessation | |
- _____

Disposition:

Referral Form Completed By:

_____	_____
Client Signature	Date (MM/DD/YYYY)
_____	_____
Staff Member Signature	Date (MM/DD/YYYY)

Black Infant Health Target Zip Codes

Adelanto 92301	Highland 92346
Apple Valley 92307,92308	Rialto 92376, 92377
Colton 92324	San Bernardino 92401, 92404, 92405, 92407, 92408, 92410, 92411
Fontana 92335, 92336, 92337	Victorville 92392, 92394, 92395
Hesperia 92344, 92345	