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| **Adolescent Family Life Program referral form**  **ventura county public health** |

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| **2240 E. Gonzales Road, Suite 250**  **Oxnard, CA 93036**  **Phone: (805) 981 5177**  **Fax: (805) 981 5260**  **brown mail # 4612** | **Eligibility Requirements:**  **Females: Pregnant/ parenting youth (21 or under)**  **males: 21 or under & involved with pregnancy and/or infant** |

This information is intended only for the use of the AFLP office. if you are not the intended recipient, please deliver it to the intended recipient. Disclosure, copying, dissemination or the taking of any action in reliance on the contents of this transmitted information is strictly prohibited. *after you complete referral, please either fax or send by brown mail.*

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| **REFERENT’S NAME** | | | | | **AGENCY :** | | | | | | **PHONE NUMBER :** | | | | | | | |
|  | | | | |  | | | | | |  | | | | | | | |
| **Referent’s Street, City and Zip** | | | | | | CAN WE FAX REFERRAL DISPOSITION TO YOU?  **yes  no** | | | | | | **FAX NUMBER :** | | | | | | |
| **client name:** | | | | | | **language :** | | **d.o.b:** | | **age:** | | | | | **Sex:** | | | **marital status :** |
|  | | | | | |  | |  | |  | | | | |  | | |  |
| **STREET, CITY AND ZIP** | | | | | | | | | | | | | **HOME/ MESSAGE PHONE :** | | | | | |
|  | | | | | | | | | | | | |  | | | | | |
| **resides with:** | | | | **relationship:** | | | | | | | | | | | | **Language:** | | |
|  | | | |  | | | | | | | | | | | |  | | |
| **attending school:** | | **name of school attending/last attended:** | | | | | | | | | | | | | | | **grade:** | |
| **yes**  **no** | |  | | | | | | | | | | | | | | |  | |
| **medical number:** | | | | | | | **client receiving CAL WORKS:** | | | | | | | **prenatal care :** | | | | |
|  | | | | | | | **yes**  **no** | | | | | | | **yes**  **no** | | | | |
| **client aware of referral:** | | | **o.k. to contact client at home:** | | | | | |  | | | | | | | | | |
| **yes**  **no** | | | **yes**  **no** | | | | | |  | | | | | | | | | |
| **REASON(S) FOR REFERRAL**: **CHECK (✓) ALL THAT APPLY** | | | | | | | | | | | | | | | | | | |
| **Home Assessment  Infant/child  Obesity**  **Safety Assessment  Asthma  Teen Parent/Pregnancy ( DOB / EDC( )**  **Nutrition  COPD  Breastfeeding Assessment**  **Prenatal Care  Anemia  Chronic/Condition/Disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Post Partum  Diabetes  Non-Adherence:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| **Comments:** |  | | | | | | | | | | | | | | | | | |
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**Agencies now involved with client:**

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| **1}** | **2}** |
| **3}** | **4}** |

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| --- |
| **Date: Signature** |

**FOR AFLP/PHN USE ONLY**

**REPORT BACK TO REFERRAL SOURCE: ⁯ NO FOLLOW UP ⁯ CLIENT REFUSUAL ⁯ UNABLE TO LOCATE ⁯ NO SUCH ADDRESS**

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NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 08/12