HEALTH SERVICES AGENCY

ECM#

CASE MANAGEMENT REFERRAL
Family Health Services
Stanislaus County Health Services Agency
917 Oakdale Rd
Modesto, CA 95355
Phone: (209) 558-7400 – Fax: (209) 558-8315
E-mail: PHN-CHS@schsa.org

Internal Use ONLY
Medi-Cal Managed Care: _____
Private Insurance: Y - N
Active: Yes - No
Non-Active: Yes - No

REFERRING AGENCY/INDIVIDUAL

Referring Agency/Name:
Address: **City:** **Zip:**
Phone:
Fax: **E-Mail:**

PARENT(s)/CAREGIVER

Name: **DOB:**
Medi-Cal/CIN#: **SSN#:**

CHILD/CHILDREN

Child Name:
Medi-Cal/CIN: **DOB:** **SSN#:**
Additional Children/DOB:

CLIENT CONTACT INFOMATION

Home Address: **City:** **Zip:**
Additional Address:
Phone/Cell#: **Message#:**
Language: **Ethnicity:**

Concern/Primary Reason for Referral:

Pregnant/Parenting

EDD:_____ G_____ P_____
PNC: _____ Entered PNC: _____
Tox screen results: _____
Substance:_____
Parent of teen knows?_____
# of children in home:_____

Medical

Health issues: _____

Records/Discharge Summary sent: _____

Infant/Child

BW _____ BL _____ BHC _____
Current wt. _____
Gestational Age _____
Discharge date _____
Tox Screen: _____
Substance:_____
Peds provider: _____
Last seen:_____ Next appt._____
Breast or Bottle Fed: _____
Type of Formula: _____

Agencies Referred

CCS Referred/Open _____
CPS Referred/Open _____
SSI Referred/Open _____
VMRC Referred/Open _____
WIC Referred/Open _____
School _____
Grade: _____
Attending: Y _____ N _____

Signature: _____ Date:_____

Case Closed Date: _____ Supervisors Signature: _____