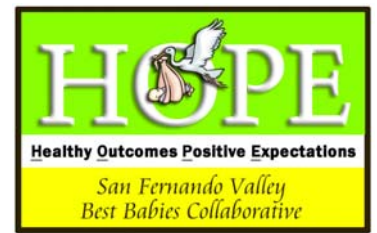


# Referral for Case Management Services



Referred by \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Referring Agency \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Please provide **H.O.P.E. SFVBBC** with the following information. All information is necessary to determine eligibility and to ensure that we link the potential client to the appropriate services. If we need additional information, we will contact you. Client must live in the following zip codes: **91331** (Pacoima), **91342** (Sylmar) and **91402** (Panorama City).

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Number \_\_\_\_\_

1. What is the Client's preferred language? \_\_\_\_\_

2. Is the Client at 300% of the Federal Poverty Line OR does client have Medical, CalWorks, Food Stamps, WIC?  
Yes / No

3. Is Client pregnant? Yes / No Client is in: 1st 2nd 3<sup>rd</sup> trimester

4. If No, what was the date of the last delivery? \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Do any of the following affect the Client?

<input type="checkbox"/> Less than 19 years old	<input type="checkbox"/> Pre-gestational diabetes (diagnosed before pregnancy)
<input type="checkbox"/> African-American	<input type="checkbox"/> Gestational diabetes
<input type="checkbox"/> Prior preterm birth	<input type="checkbox"/> Chronic Hypertension (Prior to 20 weeks)
<input type="checkbox"/> Prior low birthweight birth	<input type="checkbox"/> Currently using tobacco, drugs, or alcohol
<input type="checkbox"/> Prior fetal death (20+ weeks/ stillbirth)	
<input type="checkbox"/> Prior infant death	<input type="checkbox"/> Domestic violence
	<input type="checkbox"/> Currently or history of depression

I authorize the above named agency/person to share my information with H.O.P.E. SFVBBC. I understand that by signing I give permission for a representative of H.O.P.E. SFVBBC to contact me regarding resources and services that are available through the Collaborative.

Yo, a través de este documento, doy mi autorización de que se proporcione mi nombre, numero teléfono, fecha de nacimiento y dirección a H.O.P.E. SFVBBC. Yo entiendo que con mi firma doy permiso a un representante de H.O.P.E. SFVBBC que me llame sobre los servicios que se ofrecen por medio de este programa.

Signature/ Firma \_\_\_\_\_ Date/Fecha \_\_\_\_\_

**PLEASE FAX REFERRAL FORM TO:**

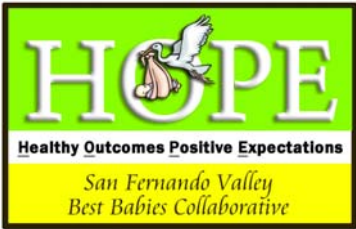
For Women <b>18</b> or younger please fax referral to: <b>818-891-6547</b> Attn: Margie Guzman	For Women <b>19</b> and older please fax referral to: <b>818-432-4404</b> Attention: Susana Escojido
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**Friends of the Family**  
...Because Families Matter



# Referral for Case Management Services



## STATUS OF Referral for Case Management Services

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referred by \_\_\_\_\_ Referring Agency \_\_\_\_\_

**Status:**

Enrolled into BBC- Date \_\_\_\_\_

Referred to Other program- Date \_\_\_\_\_ Agency \_\_\_\_\_

Declined Services- Date \_\_\_\_\_ Reason \_\_\_\_\_

If you have any questions please contact us at **818-898-1388 x51115**  
7223 Fair Avenue, Sun Valley, CA 91352