CONFIDENTIAL REFERRAL FORM

Health, Housing, & Community Services Dept
Public Health Division

Maternal, Child, and Adolescent Health
Family Support Services
West Berkeley Family Wellness Center
1900 6th St, Berkeley, CA 94710
Phone: (510) 981-5300
phmailbox@berkeleyca.gov

Please securely email this form to phmailbox@berkeleyca.gov, Attn: Family Health Services Program

REFERRAL SOURCE			
Referring Staff Name:	Title:	Phone Number:	Fax Number:
Relationship/Agency/School:	Referring Staff Email:	**Referral Date**:	

CLIENT INFORMATION					
Last Name:	First Name:	Nickname/AKA/Maiden Name:			
Street Address: ☐ Homeless (If checked, provide frequented locations if available)		City:	Zip Code:		
Home Phone Number:	Cell/Work/Alternate Phone Number:	Preferred Language:			
Date of Birth:	Sex/Gender:	Race/Ethnicity:	Medi-Cal #:	Social Security #:	
Medical Provider:	Insurance Provider:	If pregnant, EDD:			

PARENT/GUARDIAN (If Primary Client is a child)					
Last Name:	First Name:	Date of Birth:	Sex / Gender:	Medi-Cal #:	Social Security #:
Current Address (if different than client):	City:	Zip Code:	Primary Language:	Relationship:	

Step 1: Client Population (check all that apply)

☐ Infant/Child/Youth (School:) ☐ Family at risk (social issues) ☐ Homeless / Unhoused
☐ Adult (>19-54 years) ☐ Pregnant ☐ Communicable Disease
☐ Adult (>55 years) ☐ Postpartum/Newborn

Step 2: High Risk Factors (check all that apply)

☐ Difficulty accessing health services ☐ Challenges with routine medical care ☐ Lacks community support
☐ Substance abuse ☐ Victim of abuse/neglect ☐ Language and/or cultural barrier
☐ Inability to handle personal/medical affairs ☐ Other:

Step 3: Needs Assistance with/Linkage to Resources (Check all that apply)

☐ Health insurance: Covered California/Medi-Cal ☐ Medical/Dental home ☐ Scheduling medical appointments
☐ Childcare ☐ Food ☐ Counselors/Therapists ☐ Educational opportunities
☐ Employment opportunities ☐ Housing ☐ Low income resources ☐ Breastfeeding support
☐ Other:

Step 4: Reason for referral (include details i.e. medical/health issues, psycho/social, etc.)

8/2026

Thank you for your referral to the Berkeley Family Support Services Program!
For more information about our program services, please call us at (510) 981-5300.

Instructions for making referrals:

- Please make sure that the client is aware of the referral.
- All essential fields need to be completed before you can fax the referral.
- Once you are ready to submit the referral, please securely email it to PHmailbox@berkeleyca.gov., Attn: Family Support Services Program)

Contact us at 510-981-5300 (press Option 2) if you have any questions or special concerns about your client.

ADDITIONAL INFORMATION:

❖ **Who can make a Family Support Services Program Referral?**

Referrals are accepted from health care providers and other community agencies.
Self-referrals are also accepted.

❖ **When to Initiate a Family Support Services Program Referral:**

Public Health Nurses and case managers work with individuals and/or families to improve the quality of life and access to care. This is done by providing comprehensive assessment, education, and linkage to community resources. Some examples of referrals include, but are not limited to, the following:

- Inconsistent and/or late-entry into or no prenatal care
- Maternal or postpartum mental health concerns
- Needs assistance in obtaining or maintaining health insurance (i.e. Medi-Cal)
- Low-income pregnant women expecting first child
- Low-income parents with medical and/or social risk factors
- Low-income family needing assistance accessing services or resources
- Pregnant and parenting teens

❖ **Helpful Tips:**

- Please discuss with your client the benefits of home visiting and that you are making the referral.
- Home visiting & support group services are most effective when there is a "warm handoff" from the referring party.
- Provide as much of the requested information as you have available and are able to release.