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	Infant/Child	Agencies Referred
EDD:_____ G_____ P_____	BW _____ BL _____ BHC _____	CCS Referred/Open _____
PNC: _____ Entered PNC: _____	Current wt. _____	CPS Referred/Open _____
Tox screen results: _____	Gestational Age _____	SSI Referred/Open _____
Substance:_____	Discharge date _____	VMRC Referred/Open _____
Parent of teen knows?_____	Tox Screen: _____	WIC Referred/Open _____
# of children in home:_____	Substance:_____	School _____
Medical	Peds provider: _____	Grade: _____
Health issues: _____	Last seen:_____ Next appt._____	Attending: Y _____ N _____
Records/Discharge Summary sent: _____	Breast or Bottle Fed: _____	
	Type of Formula: _____	

Signature: ______________________________ Date: ____

Case Closed Date: _____________ Supervisors Signature: ______________________________________