black infant health
Empowering Pregnant and Mothering Black Women

Santa Clara County Black Infant Health Program

Patient Referral Form

Email completed forms to: *BIH@phd.sccgov.org*

Phone: (408) 937-2270 Fax: (408) 937-2291 Date:

Referral Source: (please circle one)

☐Medical Provider ☐ Social Services ☐ Returning Client ☐ Self ☐ Other Agency

(Please specify): _____

Contact Person (Phone #): _____

Patient Information:

Name: *Date of Birth:*

Address:

Zip Code:

Phone Number: *Estimated due date:*

Please check all that apply:

☐ African/African Ancestry

☐ Pregnant **OR** ☐ Less than 6 months postpartum

☐ 16 years old or older

Additional Information:

PHN Assigned: _____ **Enrolled: Yes ☐ No ☐**

F/U Date: _____ **Visit scheduled: Yes ☐ No ☐**

Santa Clara County
PUBLIC HEALTH