

**SAN DIEGO COUNTY BLACK INFANT HEALTH (BIH) PROGRAM**  
 286 Euclid Avenue, Suite 308 • San Diego, CA 92114

**REFERRAL FORM**

Please fax completed form to Attn: Janaia Bruce at (619) 262-9188  
OR e-mail to [bih@neighborhoodhouse.org](mailto:bih@neighborhoodhouse.org) OR call for pick-up at (619) 266-7466.

**Eligibility (must meet all requirements):**

- African-American woman
- 26 or fewer weeks pregnant
- 18 years of age or older

PLEASE PRINT CLEARLY

Number of Weeks Pregnant: _____		Baby's Due Date: ____/____/____	
Last Name: _____		First Name: _____	Nickname/AKA/Maiden: _____
Street Address: _____		City: _____	Zip Code: _____
Home Phone Number: _____		Cell/Work/Alternate Phone Number: _____	
Email Address: _____		Date of Birth: ____/____/____	
Additional Information: _____ _____ _____			
By signing below, I agree to be contacted by the San Diego County Black Infant Health Program.			
Client/Patient Signature: _____		Date: _____	

**SOURCE OF REFERRAL TO BIH**

Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Name: \_\_\_\_\_

Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Thank you for your referral to the BIH program.**

**For more information about BIH program services, please visit [www.sdbih.org](http://www.sdbih.org) or call (619) 266-7466.**



REFERRAL OUTCOME (For BIH Staff Use ONLY)		Referral Received: ____/____/____	BIH Staff Initials: _____
Contact Attempts:	1. Date: ____/____/____	Comments: _____	
	2. Date: ____/____/____	Comments: _____	
	3. Date: ____/____/____	Comments: _____	