

# SAN DIEGO COUNTY BLACK INFANT HEALTH (BIH) PROGRAM REFERRAL FORM

286 EUCLID AVENUE, SUITE 308, SAN DIEGO, CA 92114 | (619) 266-7466 | [WWW.SDBIH.ORG](http://WWW.SDBIH.ORG)

## ELIGIBILITY (MUST MEET ALL REQUIREMENTS)

- AFRICAN-AMERICAN WOMAN
- 18 YEARS OF AGE OR OLDER
- 26 OR FEWER WEEKS PREGNANT (30 WEEKS MAX)

## COMPLETE AND SUBMIT FORM TO JANAIA BRUCE ONE OF THE FOLLOWING WAYS:

- FAX TO (619) 262-9188
- EMAIL TO [BIH@NEIGHBORHOODHOUSE.ORG](mailto:BIH@NEIGHBORHOODHOUSE.ORG)
- CALL (619) 266-7466 FOR PICK-UP

NUMBER OF WEEKS PREGNANT _____	FIRST-TIME MOM <input type="checkbox"/> YES <input type="checkbox"/> NO
BABY'S DUE DATE _____	

LAST NAME _____	FIRST NAME _____
ADDRESS _____	CITY _____ ZIP _____
DATE OF BIRTH _____	PHONE (HOME/CELL/WORK) _____
EMAIL ADDRESS _____	
COMMENTS _____	
<b>By checking the box below, you (referring agency) are confirming the client/patient agrees to be contacted by the Black Infant Health (BIH) Program.</b>	
<input type="checkbox"/> Yes, client/patient agrees to be contacted.	Date _____

## REFERRAL SOURCE

ORGANIZATION _____	STAFF _____
ADDRESS _____	CITY _____ ZIP _____
REFERRAL DATE _____	PHONE _____
FAX _____	EMAIL _____

## REFERRAL OUTCOME (BIH STAFF USE ONLY)

REFERRAL RECEIVED _____	BIH STAFF _____
1. DATE _____	COMMENTS _____
2. DATE _____	COMMENTS _____
3. DATE _____	COMMENTS _____

THANK YOU FOR YOUR REFERRAL TO THE BIH PROGRAM!

