

**San Diego County
North
Black Infant Health (BIH) Program
REFERRAL FORM**

3156 VISTA WAY, SUITE 200, OCEANSIDE, CA 92056 | (760) 231-1887 | WWW.SDBIH.ORG

Eligibility:

- Self-identify as Black or African American
- 16 years of age or older
- Pregnant or up to 6 months postpartum

Complete & Submit Form Either By:

- Fax: (760) 231-1885
- Click: "SUBMIT FORM" at the bottom
- Email: BIH@NEIGHBORHOODHOUSE.ORG
- Call: (760) 231-1887 for pick-up

MOTHER'S INFORMATION			
Name: _____		Date of Birth: _____	
Address: _____	City: _____	Zip Code: _____	
Phone: _____	Email: _____		

Number of Weeks Pregnant: _____	First-Time Mom: <input type="checkbox"/> Yes <input type="checkbox"/> No
Baby's Due Date: _____	If postpartum (within 6 months), date of delivery: _____
Comments: _____	

REFERRAL SOURCE	
Organization: _____	Staff: _____
Referral Date: _____	Phone: _____
Fax: _____	Email: _____
By checking the box below, you (referring agency) are confirming the client/patient agrees to be contacted by the Black Infant Health (BIH) Program.	
<input type="checkbox"/> Yes, client/patient agrees to be contacted. Date: _____	

REFERRAL OUTCOME (BIH STAFF ONLY)	
Referral Received: _____	BIH Staff: _____
Date: _____	Comments: _____
Date: _____	Comments: _____
Date: _____	Comments: _____

Thank you for your BIH program referral!



The San Diego County BIH Program receives funding from the State of California, Department of Public Health, Maternal, Child, and Adolescent Health Division through the County of San Diego, Health and Human Services Agency. The San Diego County BIH Program is operated by Neighborhood House Association.