

Referral Form – Humboldt County Oral Health  
Humboldt County Dept. of Health & Human Services  
908 7<sup>th</sup> Street, Eureka, CA 95501  
**PHONE:** (707) 476-4949 **Fax:** (707) 476-4960  
**Email:** SmileHumboldt@co.humboldt.ca.us



Referring Party Information		
Agency:	Name:	Date:
Phone:	Email:	Title:

Adult/Parent/Guardian Information		Language:
Name (Last, First):	DOB:	Relationship to child: (if applicable)
Race:	Gender	Ethnicity:
Name (Last, First):	DOB:	Relationship to child: (if applicable)
Race:	Gender:	Ethnicity:

Minor/s Information		
Name (Last):	Name (First):	Gender:
Race:	DOB:	Ethnicity:
Name (Last):	Name (First):	Gender:
Race:	DOB:	Ethnicity:
Name (Last):	Name (First):	Gender:
Race:	DOB:	Ethnicity:

Mailing address:		Physical address:	
Street:		Street:	
City:	Zip:	City:	Zip:
Email:		Cell Phone:	Home Phone:

Pregnant? Yes No	Reason for referral:
Est. Delv. Date _____	

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Referral Disposition:	<b>**This section is to be completed by Oral Health staff only**</b>
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Assigned to:	Date:		
Services offered	Doesn't meet program criteria	Out of County	Declined Services

Notes:
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Please email completed form to: [SmileHumboldt@co.humboldt.ca.us](mailto:SmileHumboldt@co.humboldt.ca.us)