WILLIAM B. WALKER, M.D.
HEALTH SERVICES DIRECTOR
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PUBLIC HEALTH DIRECTOR

CONTRA COSTA
PUBLIC HEALTH
FAMILY, MATERNAL & CHILD
HEALTH PROGRAMS
597 Center Avenue, Suite 365
Martinez, California
94553-4675
PH 925 313-6254
FAX 925 313-6708

Contra Costa FIMR Program Referral Form

FAX referrals to (925) 313-6708 ATTN: FIMR Program

- ***Referrals can only be faxed/called in with the knowledge and permission of the client***
- ***Referral will be forwarded by CC FIMR to the Contra Costa Crisis Center (CCCC) for grief and bereavement support services***
- ***Client can also call CCCC directly 24/7 to 1-800-837-1818***
- ***Calls into CCCC are returned within 24 hours***

Date of Referral: ______________ Referring Agency: ____

Name and Number of Referring Staff: ____

Referral requested by *(check only one)*: □ Mother □ Father

Did you get the verbal consent from client to fax referral to CC FIMR & CCCC? □ Yes □ No

Does the client live in Contra Costa County? □ Yes □ No

Information

Name: ____ Date of Birth: __________________

Primary Contact Number: _____________________ Is it o.k. to leave a message at the above number?_______

Preferred language: _____________________ Race/Ethnicity: ______________________________________

Name & Number of Prenatal Care Provider *(only if client is the mother):* ______________________________

Hospital Name & Release Date *(only if client is the mother)*: ______________________________________

Fetal/Infant Information Date of Infant Death/Fetal Loss: __________ Type of Loss: □ Fetal □ Infant

Age at Death/Number of weeks of gestational loss: ______________________________ □ Male □ Female

Infant's Name *(if applicable):* ____

Cause of Death/Circumstances Surrounding Death *(if known)*:_____________________________________

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Date of Receipt by CC FIMR: ________

Date of Referral Faxed to CCCC: ________