



Referral to the Welcome Baby Program

(Please fax completed form to the Delivery Hospital indicated below.)

- Antelope Valley Partners for Health | *Lancaster*
Fax: (661) 951-9715
- California Hospital Medical Center | *Metro Los Angeles*
Fax: (213) 213-1276
- Centinela Hospital Medical Center | *Inglewood*
Fax: (323) 992-6041
- Citrus Valley Medical Center *West Covina*
Fax: (626) 813-7803
- Martin Luther King, Jr. Community Hospital *Willowbrook/Watts*
Fax: (323) 242-5011
- Miller Children's and Women's Hospital | *Long Beach*
Fax: (562) 595-1051
- Northridge Hospital Medical Center | *Northridge*
Fax: (818) 700-2373
- Providence Holy Cross Medical Center | *Mission Hills*
Fax: (818) 496-4462
- Providence Little Co. of Mary Medical Center | *San Pedro*
Fax: (310) 513-0417
- St. Francis Medical Center *Lynwood*
Fax: (310) 900-4719
- St. Mary Medical Center *Long Beach*
Fax: (562) 491-9824
- Torrance Memorial Medical Center | *Torrance*
Fax: (310) 513-0417
- Valley Presbyterian Hospital *Van Nuys*
Fax: (818) 781-8130
- White Memorial Medical Center *East/South East Los Angeles*
Fax: (323) 881-8603

Date: _____ Referral Agency: _____

Referred by: _____ Phone: _____

Email Address: _____

Client Information

I Am Referring: _____
Print Client's Full Name

Address: _____ Apt.#: _____

City: _____ State: _____ ZIP Code: _____

Cell Phone: _____ Alternate Phone: _____

Best Time to Call: _____ Text Message OK? Yes No

Language Preferred: English Spanish Other: _____

Client's Date of Birth: _____ Expected Due Date: _____

Delivery Hospital*: _____

***Welcome Baby Referrals:** Select the participating Welcome Baby hospital at which the client plans to deliver (see left column). Client **must** plan to deliver at one of these hospitals to enroll.

Authorization of Release

I give permission for a representative of Welcome Baby to contact me regarding possible enrollment in the Welcome Baby program.

Yo autorizo que un representante de Welcome Baby se comuniqué conmigo sobre la posibilidad de inscribirme en el programa Welcome Baby.

My decision to participate is voluntary and will not affect my eligibility to receive services.

Mi decisión de participar es voluntaria y no afectará mi elegibilidad para recibir servicios.

Printed Name/Nombre: _____

Signature/Firma: _____ Date/Fecha: _____

Please indicate if Welcome Baby can send information to the address listed above.

Por favor, indique si Welcome Baby también puede enviar información a la dirección que aparece arriba. Yes *Sí* No *No*

Urgent? Yes No Reason: _____

Additional Comments: _____