OAKLAND COUNTY MICHIGAN
HEALTH DIVISION
DAVID COULTER
OAKLAND COUNTY EXECUTIVE

Oakland County Health Division
***Public Health Nursing* Services**
Survivor Moms' Companion

Date of Referral: _____

Person completing the referral: _____

Referral Information: Oakland County Residents Only.

Name:			Birthdate:
Phone number:			
Address:	City:		Zip:
Number of Children:		Ages of Children:	
If you are pregnant, what is your due date?			
Ethnicity:	☐ Hispanic/Latino	☐ Non- Hispanic/Latino	☐ Arab ☐ Non-Arab Descent
Race:	☐ Am Indian/Alaska	☐ Asia ☐ Black/African	☐ Hawaiian/Pacific Isld ☐ White/Caucasian

If you are professional referring a client, please complete:

Agency Name:	Agency Phone:	FAX:
Agency Address:	City:	Zip:
Reason for Referral: ☐ Pregnancy services ☐ Parenting services ☐ Client reports a history of an Adverse Childhood Experience ☐ Client reports a history of traumatic experience Additional information:		

Questions: Call our Nurse-on-Call at (800) 848-5533 or
Email Marcia Andrews at andrewsm@oakgov.com