Public Health Solutions

[Program Name]
[Program Address]
[Program Phone Number]

Request for Public Health Nursing/Health Navigation Services

Please have client sign a release of information and include any pertinent medical records related to referral.

CLIENT/FAMILY INFORMATION

Date of Referral:			
Target Client Name: *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Parent/Guardian (if applicable):	☐ M ☐ F	**DOB:**	
Address:	**City:**	**State:**	**Zip:**
Phone:	**Alternate:**		
Insurance: ☐ Y ☐ N	**Insurance Provider:**	**SSN:**	
Medicaid: ☐ Y ☐ N	**Medicaid #:**	**Managed Care:** ☐ Y ☐ N	
Managed Care Provider (if applicable): ☐ Arbor Health ☐ Coventry Cares ☐ United Health Care			
Primary Language: ☐ English ☐ Spanish ☐ Other:			
Speaks/Understands English: ☐ Y ☐ N	**Interpreter Needed:** ☐ Y ☐ N		

REASON FOR REFERRAL

Reasons for Referral/Additional Information/Concerns:		
Medical Diagnoses:		
Pregnant: ☐ Y ☐ N	**EDC:**	
Primary Care Provider:		
Address:		**Phone:**
City:	**State:**	**Zip:**

REFERRAL SOURCE

Name of Person Making Referral:		
Agency/Provider/Organization:		
Address:		**Phone:**
City:	**State:**	**Zip:**

AGENCY USE ONLY

Name of PHS Staff taking referral: **Date:**

Please mail, fax, call, or email this form to: [Name, Address, Phone Number, Fax Number, Email]