Referral Form

Referral Date: ___________________

REFERRAL INFORMATION:

Client Name:	DOB:
Address:	
Phone:	Permission to Text: ☐ Yes ☐ No
If a minor, parent/guardian name:	

REASON FOR REFERRAL:

- ☐ Assessment and Care Coordination for People with Disabilities or Older Adults
- ☐ Breastfeeding Support
- ☐ Car Seats
- ☐ Environmental Health Concerns
- ☐ Follow Along Program (growth and development screenings sent by mail)
- ☐ Immunizations

Health Screenings/Services:

- ☐ Fluoride Varnish
- ☐ Lead
- ☐ Hemoglobin
- ☐ Mantoux Tuberculin Skin Test (TST)

☐ Footcare

Nurse Home Visiting/ Parenting Support

- ☐ Prenatal, Due Date: ______________________
- ☐ Postpartum Newborn Visit, Child's name and DOB: ________________________________
- ☐ Growth/Weight Check
- ☐ Parenting Support, Child's name and DOB: ________________________________

☐ *Reproductive and Sexual Health Services

☐ WIC

☐ Other: ________________________________

**Reproductive and Sexual Health Services includes pregnancy testing, birth control, emergency contraceptives, STI screening and treatment/referral, and sexual health education.*

COMMENTS | CONCERNS:

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Referred by:	Type of Worker:
Phone:	Date:

If required by referring agency:

I hereby grant, ___________________________, permission to share the above referral information with Polk County Public Health.

Signature: ____ *Date:* ________________

PLEASE FAX THIS REFERRAL FORM TO 218-281-7376 OR EMAIL TO PCPHREFERRAL@CO.POLK.MN.US