Health, Housing & Human Services
CLACKAMAS COUNTY

5I·øƴ9ŸŜ₦ǾȚ, Director
Public Health Division

Clear Form

Submit

Public Health Nursing (PHN) Referral Form

2051 Kaen Road Suite 367, Oregon City, OR 97045
Phone: 503-742-5358 • Fax: 503-655-8388 • Email referrals to HomeVisitingNurse@clackamas.us

CHILD/FAMILY CONTACT INFORMATION

Referral Date:___/___/___

Client's Name: _____ Sex: ___ Date of Birth: ____/____/____

Parent/Guardian: _____ Date of Birth: ____/____/____

Relationship to the Child: _____ Interpreter Needed: ☐ Yes ☐ No Language: _____

Home Address: _____ City: _____ Zip: _____

Primary Phone: _____ ☐ Text ☐ VM only Other Phone: _____ ☐ Text ☐ VM only

☐ **Family is aware of referral** Type of Insurance: ☐ Uninsured ☐ Private ☐ OHP/Medicaid OHP ID #: _____

REASON FOR REFERRAL

Maternal Issues:
- ☐ Teen / Young Parent
- ☐ Limited resources
- ☐ Domestic violence
- ☐ No / Late / Sporadic Prenatal care
- ☐ Substance abuse: D / A / Smoking
- ☐ Mental Health concerns / PP depression
- ☐ Medical risk
- ☐ Developmental disability
- ☐ History of poor parenting
- ☐ Other: _____

Prenatal: Due date _____
G_____ P_____ SAB _____ TAB _____

Infant / Child Issues:
- ☐ Maternal / Infant bonding
- ☐ Developmental delay
- ☐ Behavior problems
- ☐ Feeding problem (breast / bottle)
- ☐ Poor weight gain / Failure to thrive
- ☐ Substance abuse / Drug exposed
- ☐ Lost > 10% Birth weight
- ☐ Small for gestational age
- ☐ Congenital / Chronic problem
- ☐ Child Welfare involvement
- ☐ Other: _____

Infant: Gest. Age _____ Birth WT_____
HT _____ HC _____ Apgars _____ / _____

Healthy Homes (Asthma):
- ☐ Poor Control
- ☐ Multiple ED / PCP asthma related visits
- ☐ Medication compliance and/or understanding
- ☐ Environmental factors
- ☐ Asthma Action Plan
- ☐ Asthma Counseling and Education need

ADDITIONAL INFORMATION

_____
_____
_____
_____
_____
_____
_____
_____
_____

Child/family has also been referred to:
- ☐ Specialty Health Care
- ☐ Early Intervention/Early Childhood Special Education
- ☐ Developmental Disabilities
- ☐ Early Head Start/Head Start
- ☐ Mental Health
- ☐ Other:_____

REFERRAL SOURCE

Name: _____ Facility: _____

Phone: _____ Office Fax: _____

Primary Care Provider (PCP) _____

PCP Address:_____ Phone: _____

Would you like feedback concerning this referral? ☐ Yes ☐ No

Primary contact for receiving feedback about referral: _____ Best time to communicate: _____

Best communication method for feedback: ☐ Fax: _____ ☐ Phone: _____