

Public Health Nurse Information Form for Specialty Consultation

Date of Referral: __/__/__

Referral To:

- DCH/CDRC (Portland)
- Legacy Health (Emanuel)
- Providence (Portland)
- St. Charles MC (Bend)
- CDRC (Eugene)
- Rogue Valley MC (Medfd)
- Other

Referring Provider:

PHN Name:

Address:

Phone:

Fax:

E-mail

PHN works these days
M T W TH F

Other Provider Info:

Child's PCP:

Specialists:

Other Agency Involvement:

- Early intervention
- Develop. Disabilities
- SSI
- School
- Other (list)

Attachments:

- Nursing assessment
- Growth charts
- Screening results
- ROI

Patient Information:

Child's Name: _____ M F

Address: _____

City, State, Zip: _____ Date of Birth __/__/__

Parent/Guardian Name(s): _____

(Please check preferred contact phone number)

Home _____ Cell _____

Work _____

Interpreter needed? Yes No If yes, Language: _____

Insurance Co.: _____ Member ID: _____ Grp. # _____

Address: _____ Phone: _____

Subscriber Name: _____ Subscriber DOB: _____

For intake office use only

Auth #: _____

Notes: _____

Child's Diagnoses:

Parent Concerns/reason for visit:

Provider Concerns/reason for visit:

Date measured: _____

Current Wt: _____ Height _____ Head circum. _____

Current Medications:

Current Therapies: _____

Current Feeding Plan:

**This is a generic form that can be used to refer to all clinics. This form was developed by the CaCoon Program at the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) www.occyshn.org