Public Health
Seattle & King County

Public Health Nurse Referral

Please fax to **206-296-4679**
(Do not email)

Thank you for your referral to Public Health – Seattle & King County! **Date**_____

Client:

Name _____

AKA/former name_____

DOB _____ Gender _____

Address _____

_____

Phone #s (or other contact info)

_____

_____

Provider One # _____

If infant/child, mother/caregiver's name:

Name _____

DOB _____ Gender _____

Provider One # _____

Other siblings, if included in referral:

Name _____

DOB _____ Gender _____

Name _____

DOB _____ Gender _____

Type of Referral:

□ Pregnancy – EDD _____

Gravida _____ Para _____

□ Nurse-Family Partnership – EDD _____

□ Post-Preg. – Preg. End Date _____

□ Children with Special Heath Care Needs (CSHCN)

Dx:_____

□ Infant (up to 1 year)

Birth weight _____ Gestational age_____

□ Other /Unknown _____

If interpreter needed, language:

Reason for Referral/Concerns:

□ Breastfeeding Concerns □ Current CPS Involvement

Referred by:

Name: _____

Agency: _____

Contact phone: _____

Would you like to be contacted when PHN is assigned? □ Yes □ No

Is client/family aware of referral? □ Yes □ No

Client approval for texting:

□ Client consents to introductory communication via text (see *Client Approval for Texting* form).

Thank you for taking this extra step to ensure we are able to make contact with the client you are referring to us!