Maternal Child & Reproductive Health Program
Public Health Nurse Referral

Washington County Department of Health & Human Services, Public Health
155 North First Avenue, MS-23A, Hillsboro, OR 97124-3072
503-846-4872 (Admin) ◆ 503-846-5717 (Supervisor) ◆ **FAX**: 503-846-5712

For WashCo Use Only

RN:
Progr:
Date:

☐ **Client** ☐ **Mom:** _____ (last name) _____ (first name) **DOB:** ____-____-____

☐ **Spouse** ☐ **Partner:** _____ (last name) _____ (first name) **DOB:** ____-____-____

☐ **Baby** ☐ **Child:** _____ (last name) _____ (first name) ☐ **M** ☐ **F** **DOB:** ____-____-____

Address: _____ **Apt.#:** _____ **City:** _____ **Zip: 97**____

Phone: ____-____-____ ☐ **H** ☐ **C** **Additional Phones:** ____-____-____ ☐ **H** ☐ **C** ____-____-____ ☐ **H** ☐ **C**

☐ **English Speaking** ☐ **Other Language:** _____ **Will we need an interpreter?** ☐ **Y** ☐ **N**

Referred By: _____ **of** _____ **Phone:** ____-____-____

Aware of Referral? ☐ **Y** ☐ **N** **Health Care Provider:** _____ (Last Name) _____ (First Name) **Phone:** ____-____-____

Health Insurance: ☐ **Private Insurance** ☐ **Medicaid** ☐ **Cawem** ☐ **Mom#** _____ ☐ **Baby#** _____

Reason(s) for Referral

Infant/Child

Gestational age at birth _____ Wg (g) _____ Lg _____ HC _____ Apgars _____ ☐ Vag ☐ C-Sec ☐ Forceps

☐ Drug-exposed infant ☐ Congenital/chronic problem ☐ Developmental delay	☐ Feeding problem (breast/bottle) ☐ High wt ☐ Low wt ☐ Failure to thrive ☐ Twin/triplet	☐ Prematurity ☐ Other — list in comments

Prenatal — Due Date: ____-____-____ **G** _____ **P** _____ **AB** _____ **L** _____

☐ Prenatal care > 27 weeks ☐ History of preterm birth ☐ History of fetal demise ☐ Nutrition: overweight ☐ Inadequate gain ☐ History of gestational diabetes ☐ Pre-eclampsia/toxemia ☐ Developmental delays	☐ First time mom ☐ Gransmultiparous ☐ PN with twins/triplets/more ☐ History of low birth weight ☐ History of SIDS	☐ High-risk psychosocial concerns • Domestic violence • Mental health diagnosis including Post-Partum Depression • Substance abuse: ☐ Drugs ☐ Etoh ☐ Smoking • History of poor parenting/attachment • History of Child Welfare involvement • History of poor attendance at appointments

Additional Information: _____

_____

_____

★**Feedback requested?** ☐ **Y** ☐ **Date:** ____-____-____ **Signature of Writer:** _____