



Growing Families San Juan Islands

Universally-Offered Public Health Home & Community Visiting Referral Form

Please complete as much information as possible and return this form to San Juan County Health & Community Services by sending via secure email to growingfamilies@sanjuancountywa.gov.

Referral Information (required)

Referring Organization or Individual: _____
 Referral Submitted By (staff/provider name – if self-referral, write “self”): _____
 Date of Referral: _____

Basic Client/Patient Information (required)

Client/Patient Name: _____ DOB: _____
 Primary Phone Number: _____ Home Cell/Mobile
 Is the client/patient aware of the referral? Yes No If no, explain: _____

Additional Client/Patient Information (optional)

Street Address: _____ Apartment #: _____
 City: _____ Island: _____ State: _____ Zip: _____
 If client/patient is child, parent name: _____
 Primary Language: _____ Will we need an interpreter? Yes No
 Health Care Provider (if not referral source): _____ Phone Number: _____
 Health Insurance: Private Insurance Medicaid – P1#: _____ Other/Uninsured: _____
 Client/Patient is: Pregnant Mother (Due Date: _____) Postpartum Mother (Birth: _____)
 Infant/Child (Sex: Male Female) Other (specify): _____
 Other Parent/Caregiver _____

Specific Program Referral (optional)

Universally-Offered Public Health Nurse Community-Visiting (Growing Families San Juan Islands)
 Women, Infants & Children (WIC) Nutritional Program (Child 0-5 years) / Breast Feeding Peer Counselor Program
 Other/Please Assess for Eligibility/Need(s)

Reason(s) for Referral (optional)

<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> First-Time Mother	<input type="checkbox"/> Congenital/Chronic Problem
<input type="checkbox"/> History of Preterm Birth	<input type="checkbox"/> History of LBW	<input type="checkbox"/> Failure to Thrive
<input type="checkbox"/> History of Fetal Demise	<input type="checkbox"/> History of SIDS	<input type="checkbox"/> Prematurity
<input type="checkbox"/> Nutrition/Overweight (Mother)	<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> High-Risk Psychosocial Concerns
<input type="checkbox"/> Inadequate Gain (Mother)	<input type="checkbox"/> Infant/Child Feeding Problem	<input type="checkbox"/> Perinatal/Postpartum MH Concern
<input type="checkbox"/> History of Gestational Diabetes	<input type="checkbox"/> Needs Breastfeeding Support	<input type="checkbox"/> Foster
<input type="checkbox"/> Pre-Eclampsia/Toxemia	<input type="checkbox"/> Drug-Exposed Infant	<input type="checkbox"/> Other/Please Assess for Need(s)

Additional Information: _____

Follow-Up Requested? Yes No

Release of Information (ROI)

I authorize the organization or individual submitting this referral form to San Juan County Health & Community Services to disclose or give access to confidential information about me and/or my child, including relevant protected health information (PHI).

Yes No **Signature of Client/Patient:** _____ **Date:** _____