Marion County OREGON Health & Human Services

MCHHS Early Childhood Nursing

3160 Center St. NE Salem, OR 97301
Phone: 503-373-3781 Fax: 503-566-2948

Please complete this form to the best of your ability. Medical providers may send a demographic page and medical records in addition to completing Reason for Referral section.

DATE: **REFERRED BY OFFICE/AGENCY:** **PHONE:**

CONTACT INFORMATION FOR INDIVIDUAL BEING REFERRED

First Name: **Last Name:**

Date of Birth: **Sex:** Male Female Other:

Home Address: **City/State/Zip:**

Mailing Address: **City/State/Zip:**

Primary Language: **Phone Number:**

Willing to Receive Text/SMS?

INSURANCE: **ID NUMBER:** **GROUP NUMBER:** **NO INSURANCE:**

PRIMARY CARE PROVIDER: **CLINIC NAME:** **PHONE NUMBER:**

PARENT/GUARDIAN INFORMATION

Name: **Name:**

Relationship to Client: **Relationship to Client:**

Phone Number: **Phone Number:**

Reason For Referral:

Individual is:	**Services offered based on individual need:**
☐ *Pregnant*	Prenatal education, Case management services during pregnancy.
☐ *Newborn/Postpartum under 12 Weeks*	Newborn Health Assessment, case management needs assessment. Postpartum health assessment, case management needs assessment.

Individuals with the following conditions are offered ongoing growth/development screening and/or case management services:

Prematurity
Gestational Age (Weeks carried before birth)?

Underweight at Birth/Failure to Grow

Suspected Hearing Loss

Complications at birth placing them at risk for a developmental delay

Child with parent experiencing mental health conditions, SDOH or Financial Risk Factors, or medical conditions which put child at risk for delays in growth or development. (Please explain in “other” section.)

Existing Medical Diagnosis:

Condition: Diagnosis Code:

OTHER REASONS FOR REFERRAL, OR ADDITIONAL INFORMATION: