PUBLIC HEALTH NURSING REFERRAL

Cities of Bloomington, Edina and Richfield

Fax: 952-563-8997
Phone: 952-563-8900
Email (only if SECURE):
publichealth@bloomingtonmn.gov

No weekend or holiday services available.

Today's Date: _____

Name: _____

Birth Date: _____ **Gender:** ◯ **Male** ◯ **Female**

Address: _____

City: ◯ **Bloomington** ◯ **Edina** ◯ **Richfield** **Zip:** _____

Preferred phone: _____ **Alternate phone:** _____

Client is aware of this referral: ◯ **YES** ◯ **NO** **Health Care Provider is aware of this referral:** ◯ **YES** ◯ **NO**

Health Care Provider name: _____ _____
(First, Last) **(Phone, ext)**

Parent/guardian: if above client less than 18 years of age **Birthdate:** **Relationship:** **Phone** (if different)

_____ _____ _____ _____

_____ _____ _____ _____

Other Family Members: (if being referred also)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Language(s) spoken in the home: _____ **Interpreter needed:** ◯ **YES** ◯ **NO**

Insurance: ☐ **Private** ☐ **No insurance** ☐ **M.A./PMAP#** _____

If postpartum: ☐ **Breastfeeding** ☐ **Bottle feeding** ☐ **Unknown**

REASON FOR REFERRAL:

Referral source name and title: _____

Agency: _____ **Phone:** _____