Macomb County Health Department

43525 Elizabeth Rd.
Mt. Clemens, MI 48043
Phone: 586-469-5520 Fax: 586-469-5885

Referral for Public Health Nursing Services

Parent/ Guardian Name: ______________________________________ **DOB:** ____________ **Sex: F** ☐ **M** ☐
Marital Status: S ☐ **W** ☐ **M** ☐ **D** ☐ **SEP** ☐ Name of Spouse/SO: ____________________
Address: ________________________________ **Apt #**: ________ **City**: __________________ **Zip**: ____________
Phone #:____________________________ **Cell/ Alt #**: ____________________
Type of Insurance: _____________________________________ /None ☐ Race:_____________________
Prenatal Care Onset: ____________________________________

Infant / Child's Name:_____________________________________ **DOB:**______________ **Sex: F** ☐ **M** ☐
EDC: _________ **WK Gest.:**_________ **Birth Weight:**_________ **Length:**_________ HC:_________
Apgar: 1 min: ______ 5 min: ______ Vag / C-Section **Hospital:**______________________________________
Race: _______________
If Multiple:
Infant/ Child's Name:____ Sex: F ☐ M ☐
Birth Weight:________ Length: _______ HC: _______ Apgar: 1 min: _______ 5 min:_______

Reason For Referral:

- ☐ New Parents
- ☐ Antepartum Education
- ☐ Growth & Development Education
- ☐ Postpartum Blues/ Depression / Psychosis
- ☐ Resources Education
- ☐ Safety
- ☐ Feeding / Nutrition
- ☐ Other ____________________________________
- ☐ Teaching Re: ____
- ☐ Medical Dx: ____

History / Notes (Medical, psychosocial/ family, pregnancy, special problems/ complications):
Lab Data (ie. lead levels):

Current Community Resources/ Supports/ Other Referrals Made:
☐ DHS ☐ CPS ☐ WIC ☐ CSHCS ☐ Early On ☐ Other: _________________
Physician: ____ Phone #: ______________________
Practice: ____ Last Seen: ________ Rtn Appt:_________

Referred By: ____________________________________ **Agency:**_____________________________________
Date: ________________ **Ph #:** _______________________ **Is Family Aware of Referral? YES** ☐ **NO** ☐

MCHD OFFICE USE
Date: ______________ Record #: _______________ FF#: _____________ Baby #: __________
MCHD INFO: Referral taken by: ____
Assigned RN: ____