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 (please print): ____

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:	**Birth date:**	**Relationship:**	**Phone** (if different)
____	_____________	____________	____________________
____	_____________	____________	____________________

Other Family Members:

____ _____________ ____________

____ _____________ ____________

____ _____________ ____________

Language 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: ____________________________________ **Agency:** _____________________________
(Please print - include title, if any)

Phone: ____

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PUBLIC HEALTH DIVISION
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AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITIES EMPLOYER