Submit via Secure Email

San Juan County Health & Community Services
Community Health Services Division ● 145 Rhone Street, (PO Box 607) Friday Harbor, WA 98250
360-378-4474 (Admin) ● 360-774-9350 (Manager) ● FAX: 360-378-7036

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 jessican@sanjuanco.com, by faxing to 360-378-7036, or by delivering to our office at the address above.

Referral Information (required)

Referring Organization: _____
Referral Submitted By (staff/provider name): _____
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** (incl. Newborn Outreach and Maternity Support Services)
☐ **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)

☐ Prenatal Care	☐ First-Time Mother	☐ Congenital/Chronic Problem
☐ History of Preterm Birth	☐ History of LBW	☐ Failure to Thrive
☐ History of Fetal Demise	☐ History of SIDS	☐ Prematurity
☐ Nutrition/Overweight (Mother)	☐ Developmental Delays	☐ High-Risk Psychosocial Concerns
☐ Inadequate Gain (Mother)	☐ Infant/Child Feeding Problem	☐ Perinatal/Postpartum MH Concern
☐ History of Gestational Diabetes	☐ Needs Breastfeeding Support	☐ Foster
☐ Pre-Eclampsia/Toxemia	☐ Drug-Exposed Infant	☐ 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**: _____