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:

☐ *Pregnant*

Services offered based on individual need:

Prenatal education, Case management services during pregnancy.

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

☐ Prematurity

Gestational Age (Weeks carried before birth)? _____

☐ 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: _____

☐ Suspected Hearing Loss

☐ Underweight at Birth/Failure to Grow

☐ Complications at birth placing them at risk for a developmental delay

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OTHER REASONS FOR REFERRAL, OR ADDITIONAL INFORMATION: