Maine Center for Disease Control and Prevention

Public Health Nursing Referral

Please Complete and Fax to PHN Central Referral

Fax: 207-287-4577 **Phone: 1-888-644-1130**

Referent Information

Referent Organization: _____ Referral Date: _____/_____/_____

Contact Person Name: _____ Contact Person Phone: (_____)_____

Referred By: ☐Self/Client ☐Healthcare Provider ☐Nurse ☐Other:_____

Client Information

Client Full Name: _____ Date of Birth: _____/_____/_____

(If referring a minor/dependent client please include parents or guardian information below)

Guardian Full Name: _____ Date of Birth: _____/_____/_____

Relationship to Client: ☐Mother ☐Father ☐Guardian Language:_____

Phone 1: (_____)_____ Phone 2: (_____)_____

Home Address: _____

Town / City: _____, MAINE Zip Code: _____

Mailing Address (if different): _____

Town / City: _____, MAINE Zip Code: _____

Insurance Status: ☐MaineCare ☐Medicare ☐Private Insurance ☐Uninsured

Referral Type

☐Infectious Disease ☐Adult/Elder ☐Refugee Health ☐Lead ☐Other:_____

Reason for Referral / Diagnosis / Problem

_____

_____

_____

_____

_____

Additional Information

Primary Care Provider: _____ Phone: (_____)_____

Medications: _____

Other Information: _____

_____

Revised 4/2019