Public Health
Seattle & King County

Parent Child Health Referral

Questions? 206-263-8374

Please fax to **206-296-4679**
(Do not email)

Thank you for your referral to Public Health – Seattle & King County! **Date**_____

Patient:

Name _____

AKA/former name_____

DOB _____ Gender _____

Provider One # _____

Address _____

_____

Phone/contact info _____

_____

If interpreter needed, language: _____

If infant/child, mother/caregiver's name:

Name _____

DOB _____ Gender _____

Provider One # _____

Other siblings, if included in referral:

Name _____

DOB _____ Gender _____

Name _____

DOB _____ Gender _____

Type of Referral: *(select all that apply)*

☐ Pregnancy – EDD _____

☐ Post-Pregnancy – Birth/End Date _____

☐ Home visit

☐ WIC/office services

☐ Nurse-Family Partnership (NFP)

☐ Children with Special Health Care Needs (CSHCN)

Dx:_____

☐ Infant (up to 1 year)

Birth weight _____ Gestational age_____

☐ Other _____

☐ Birth notification only *(no concerns)*

Reason for Referral/Concerns: ☐ Breastfeeding ☐ Behavioral Health ☐ Current CPS Involvement ☐ Other:

Referred by:

Name: _____

Agency: _____

Contact phone: _____

Would you like to be contacted when PHN is assigned? ☐ Yes ☐ No

Is patient/family aware of referral? ☐ Yes ☐ No

Patient approval for texting:

I agree to get text messages from Public Health – Seattle & King County to tell me about the services available to me. No more than 2 messages will be sent to me if I don't reply.

Patient signature _____

Date _____

Text messages may expose your personal information. Please password-protect your phone.

Public Health
Seattle & King County

Parent Child Health/Family Health
Public Health – Seattle & King County
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Fax: 206-296-4679

Form #: PH-CHS-PCH-1316 EN-SP (rev. 10/18)

Client Approval for Texting

Consent

Client Name: _____

HR #: _____

D.O.B.: _____