

PRENATAL, POSTPARTUM AND EARLY CHILDHOOD PUBLIC HEALTH NURSING REFERRAL

Client/Parent/Guardian aware of referral? <input type="checkbox"/> YES <input type="checkbox"/> NO Note – Public health will not contact if client unaware of referral			
Referral Date	Client Last Name	Client First Name	
		Parent/Guardian Name (if applicable)	
Date of Birth (dd/mm/yy)	Age	Gender	Language Spoken: Fluent in English <input type="checkbox"/> Yes <input type="checkbox"/> No
Address and postal code			
Phone #		Alternate method of contact	
Personal Health Number		Name of Primary Care Provider	

Request for Public Health Nurse Follow-Up (Check all that apply):		
<input type="checkbox"/> Maternal <input type="checkbox"/> Postpartum <input type="checkbox"/> Prenatal Expected Date of Delivery: _____	<input type="checkbox"/> Newborn/Infant Age: _____ Gestational Age: _____	<input type="checkbox"/> Child Age: _____
<input type="checkbox"/> Prenatal Physiological Health <input type="checkbox"/> Postpartum Physiological Health <input type="checkbox"/> Breasts/Chestfeeding <input type="checkbox"/> Mental Health <input type="checkbox"/> Alcohol/Substance/Tobacco Use <input type="checkbox"/> Financial Stress <input type="checkbox"/> Relationship Issues <input type="checkbox"/> Lack of Support/Isolation <input type="checkbox"/> Less than 25 years of age <input type="checkbox"/> History of Trauma <input type="checkbox"/> Other	<input type="checkbox"/> Feeding <input type="checkbox"/> Weight <ul style="list-style-type: none"> • Birth weight _____ • Current weight _____ <input type="checkbox"/> Jaundice <input type="checkbox"/> Development <input type="checkbox"/> Parenting/Attachment <input type="checkbox"/> Other	<input type="checkbox"/> Growth <input type="checkbox"/> Feeding/Nutrition <input type="checkbox"/> Development <input type="checkbox"/> Behaviour <input type="checkbox"/> Parenting/Attachment <input type="checkbox"/> Immunizations <input type="checkbox"/> Community Resources <input type="checkbox"/> Other

Summary of Concerns

Referred By: Last Name _____ First Name _____ Date _____

Signature/Title _____ Phone _____ Fax _____

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Information for Referring Partners

Clients referred through this process will be contacted by a Public Health Nurse (PHN). The PHN may provide direct nursing services or refer on to appropriate community resources. Clients referred can be prenatal, postpartum or children birth to six years of age.

Public Health nursing services focus on:

- Maternal, infant, or early childhood nutrition
- Breast/Chest feeding decision making and support
- Perinatal depression and anxiety screening and support
- Tobacco, alcohol and substance misuse support
- Transition to parenthood/effective parenting and attachment
- Development assessment (Ages and Stages Questionnaire)
- Infant safety
- Immunization/communicable disease
- Support and referral to community resources

Public Health nursing services will be based on individual client needs and may be delivered as:

- Individual follow up in the home, public health office or by phone
- Group based facilitated discussions/education/support (based on local availability)

Please complete the demographic information fields so that parent/guardian can be contacted for follow-up.

It is important to indicate that you have discussed the referral with client or parent/guardian, as we will only contact if the client or parent/guardian is aware.

If you have any questions, or prefer to refer by telephone, call your local public health office (see list below).

Contact the Community Health office in the area which the family lives

Richmond Phone 604 233 3150 Fax 604 233 3198

Vancouver Phone 604 301 2227 Fax 604 321 2947

North and West Vancouver, Bowen Island or Lions Bay
Phone 604 983 6700 Fax 604 983 6883

Squamish, Whistler or Pemberton
Phone 604 892 2293 Fax 604 892 2327

Sunshine Coast:
Gibsons Phone 604-984-5070 Fax 604-984-5075
Sechelt Phone 604-885-5164 Fax 604-885-9725

Powell River Phone 604 485 3310 Fax 604 485 3305