

Serving first time parents in Big Stone, Chippewa,
 Douglas, Grant, Kandiyohi, Lac qui Parle, Lincoln,
 Lyon, McLeod, Meeker, Murray, Pipestone, Pope,
 Redwood, Renville, Rock, Sibley, Stevens, Swift,
 Traverse and Yellow Medicine Counties
 Visit our website: www.shnfp.org



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|--|--|-----|-----|--|-----------|----|------------------------|--|----------|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| Referral Requirements: (must meet all three criteria) | | | | | | | | | | Fax, call, or send referrals to: | | | | | | | | | | | | | |
| Lives in a participating county? | | | | | YES | | | | NO | | Katie Jensen, RN, PHN 10 E. Highway 28 Morris, MN 56267 Phone: 320-287-2585 Fax: 320-589-7433 katie.jensen@shnfp.org | | | | | | | | | | | | |
| First Time Mother before 28 weeks gestation? | | | | | YES | | | | NO | | | | | | | | | | | | | | |
| Low income? (includes: MA, MFIP, WIC eligible) | | | | | | | | | | | | | | | | | | | | | | | |
| Enrolled in Medical Assistance | | | YES | | | | NO | | Referred | | | | | | | | | | | | | | |
| Enrolled in WIC Program | | | | | YES | | | | NO | | | | | | | | | | | | | | |
| Family Income: (if not participating in WIC or MA) | | | | | \$ | | | | | | | | | | | | | | | | | | |
| Interpreter Needed? | | YES | | | | NO | | | | If yes, please list primary language | | | | | | | | | | | | | |
| Client Name: | | | | | | | | | | Birth Date: | | | | | | | | | | | | | |
| Address: | | | | | | | | | | Cell phone: | | | | | | | | | | | | | |
| | | | | | | | | | | Home phone: | | | | | | | | | | | | | |
| | | | | | | | | | | Best time to call: _____ am ___pm ___ Morning ___ Afternoon ___ Evening | | | | | | | | | | | | | |
| Email Address: | | | | | | | | | | Other phone: Who?: | | | | | | | | | | | | | |
| OK to mail information? | | | Y | | N | | OK to leave a message? | | | Y | | N | | | | | | | | | | | |
| Physician: | | | | | Due Date: | | | | | Weeks gestation: | | | | | | | | | | | | | |
| Health Care Coverage: | | | | | | | | | | | | | | | | | | | | | | | |
| Marital Status: | | | | | | | | | | Lives with: | | | | | | | | | | | | | |
| Emergency Contact Person: | | | | | | | | | | Relationship to client: | | | | | | | | | | | | | |
| Reason for Referral / Relevant Data: | | | | | | | | | | | | | | | | | | | | | | | |
| Referring Agency: | | | | | | | | | | Phone #: | | | | | | | | | | | | | |
| Referring Person: | | | | | | | | | | Date: | | | | | | | | | | | | | |