State of Hawaii
Health Department

**REQUEST FOR NURSING SERVICES**

Public Health
Nursing Branch

DATE:_____

**CLIENT:** _____ SEX:___ BD:__/__/__ School / Gr:_____
Last First

_____ SEX:___ BD:__/__/__ School / Gr: _____

_____ SEX:___ BD:__/__/__ School / Gr: _____

**ADDRESS:** _____ **APT. NO.**_____ **HOME PHONE:** _____

Mailing address (if different): _____

**FATHER:** _____ BD:__/__/__ Phone:_____
(Man) Last First if different work
other

**MOTHER:** _____ BD:__/__/__ Phone:_____
(Woman) Last First if different work
other

Other Contact Person / Phone: _____

**MEDICAL INSURANCE & NUMBER:** _____

**PHYSICIAN / PCP:** _____

**Medical/Clinical Diagnosis:**_____

**REASON(S) FOR REFERRAL** Nursing assessment and memory concerns

**SIGNIFICANT INFORMATION** _____

**PLANNED DISCHARGE DATE:** _____ HOSPITAL: _____

OTHER AGENCIES INVOLVED OR REFERRED TO: CONTACT PERSON & PHONE NUMBER:

_____ _____

_____ _____

**REQUESTED BY:** _____ Title: _____ Agency: _____

**ADDRESS:** _____ **Phone:** _____

PHN SUMMARY:_____

**For PHN Office Use Only:**
Date Rcvd: _____ By: _____ CT /Assigned PHN: _____

Currently Carried ☐ No ☐ Yes By_____Previously Carried by_____Registration#_____
QA_____ Live_____

DISPOSITION: ☐ Admitted ☐ Disposition Letter Sent; Date_____ Not admitted date:_____
☐ L Unlocated ☐ R Refused PHN services ☐ C Assistance from Other Agency/Program ☐_____

PHN 10R – Rev 11/2003