# Manitoba Public Health Nurse
# Prenatal Referral

| Date (MONTH/DD/YYYY): | ◯ Verbal Consent Obtained |
|---|---|

## *Personal Information*

| Client Name: | | | | Phone: |
|---|---|---|---|---|
| Physical Address: | | | | Alternate Phone: |
| Mailing Address: | | | | Lives on Reserve: ◯ Yes ◯ No |
| Temporary Address: | | | | |
| MFRN#: | PHIN: | Nunavut #: | Treaty #: | |
| Birthdate (MONTH/DD/YYYY): | | Language spoken: | | Interpreter Required: ◯ Yes ◯ No |
| Client Age: | Gravida: | Para: Living children | | EDD (MONTH/DD/YYYY): |

## *Referral*

| | | |
|---|---|---|
| ◯ Nurse | ◯ Nurse Practitioner | ◯ Child & Family Services |
| ◯ Physician | ◯ Physician Assistant | ◯ Self-Referral |
| ◯ Midwife | ◯ Healthy Baby/Child Health Start | ◯ Other: |

Referral Site & Location:

| Fax: | Telephone: | E-mail: |
|---|---|---|

Referral Completed by:

## *Travelling for Birth (if applicable):*

| Anticipated date of arrival (MONTH/DD/YYYY): | Delivering Facility: |
|---|---|
| Accepting Provider (Family Physician/Obstetrician/Midwife): | Name: |
| Provider Address: | Provider Phone: |
| Clients' Temporary Address: | Temporary Phone: |

## *Additional Information*

## *Public Health Nurse Response to Referral*

**Contact with client:** ◯ Yes ◯ No, Rationale:

| **Families First Screen:** ◯ Yes ◯ No | Families First/Strengthening Families Home Visiting: ◯ Yes ◯ No |
|---|---|

**Service Plan:** PHN continued follow-up ◯ Yes ◯ No

◯ Prenatal Education/Resources ◯ Prenatal Benefit ◯ Community Resources/Healthy Baby Programs
◯ Referral/s:

Other/Comments:

| PHN Signature: | Telephone : | Date (MONTH/DD/YYYY): |
|---|---|---|
| Faxed back to: | Date (MONTH/DD/YYYY): | Response Required: ◯ Yes ◯ No |

**REFFERING SITE: Fax referral with fax cover sheet to Central Intake at 204-940-2635**

**PUBLIC HEALTH: Fax completed referrals with fax cover sheet to referring site**

Manitoba

## *Prenatal Referral Form to Public Health Instructions for Completion*

✔ Please complete all sections of the prenatal referral form. If information is unavailable, leave item blank.
✔ Please print neatly using black ink to increase fax transferability.
✔ Please fax the completed referral form to: 204-940-2635

| | |
|---|---|
| Date | Record today's date as Month/DD/YYYY |
| Verbal Consent | As this process is voluntary, please check the box to indicate client's awareness and consent to the PHN referral. |
| Client Name | Client's full name and alias names if known. |
| Physical Address | Client's physical address where they permanently reside |
| Mailing Address | Client's mailing address or postal box |
| Temporary Address | Indicate temporary address if different from permanent physical address |
| Phone # | Client's phone number |
| Alternate Phone # | Alternate phone number/s where client can be reached E.g. boarding home number, hotel number, temporary address number |
| MFRN# | Client's Manitoba Family Registration number (6 digits) |
| PHIN # | Client's Manitoba Personal health identification Number (9 digits) |
| NU# | Client's Nunavut Health Card number (9 digits) |
| INAC (Treaty) # | Indian and Northern Affairs Canada (INAC) Number. Also known as The Department of Indian Affairs of Northern Development (DIAND), Treaty or Status Number. (10-digits). If have an INAC number, check if client lives on or off reserve. |
| Birthdate | Client's date of birth (Month/Day/Year) |
| Language/s Spoken | Client's language/s spoken |
| Interpreter Required | Check box indicating if client requires an interpreter |
| Client Age | Client's age in years |
| Gravida | Client's number of pregnancies |
| Para | Client's number of births |
| Living children | Indicate number of living children |
| EDD | Client's expected date of delivery with this pregnancy, recorded as Month/DD/YYYY |
| Referred By | Check appropriate box. Specify the referral site and location. Provide the fax and phone number. Include the name of the person who completed the referral form. |
| Additional Information | Provide additional relevant information to this pregnancy. Examples: single, supports, substance use, mental illness, relationship issues, medical history, medications, previous pregnancy information, referrals. |

## *Travelling for Birth (if applicable)*

| | |
|---|---|
| Anticipated date of Arrival | Date the client is anticipated to arrive in the delivering community recorded as Month/DD/YYYY |
| Delivering Facility | Provide the name/location of the facility where the birth is planned |
| Accepting Provider | Circle the accepting provider. Indicate the health care provider's name, office address and telephone number |
| Client Temporary Address/ Phone # | Indicate temporary address where the client is staying –E.g. boarding house, hotel, family. Include phone number associated with temporary address |
| **OFFICE USE ONLY:** Public Health Nurses Response to Referral | The Public Health Nurse (PHN), to facilitate routine communication, will fax the completed referral form back to the referral source. By checking the boxes, the PHN advises if they have contacted the client, completed the screen, and client has entered the Families First/ Strengthening Families Home Visiting Program. The service plan indicates PHN intent for ongoing prenatal contact. By checking boxes, the PHN indicates routine prenatal education and community resources were discussed. Lines are included to document referrals and additional basic information pertinent to the coordination of client care. Where detailed client health information is being shared between providers, the PHN will utilize their regions communication form to document their full assessment, interventions, and plan. |