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

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

PUBLIC HEALTH: Fax completed referral 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:

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.