

**ELKHART COUNTY HEALTH DEPARTMENT**

608 Oakland Avenue, Elkhart, IN 46516  
Phone:(574-523-2127 Fax:(574)523-2145  
Health Promotion Referral

Date: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Referral Agency: \_\_\_\_\_  
Referred By: \_\_\_\_\_

Hospitalization: Adm. Date \_\_\_\_\_ Dischg. Date: \_\_\_\_\_

Child Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Birth Wt. \_\_\_\_\_ Present Wt. \_\_\_\_\_ Sex \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. Physical and/or Assessment:

B. Psychosocial Assessment:

**Nursing plans for follow-up:**

Copy to MD \_\_\_\_\_ Date Sent \_\_\_\_\_ Copy to Referral Agency \_\_\_\_\_ Date Sent \_\_\_\_\_

\_\_\_\_\_  
**RN Signature**