PUBLIC HEALTH REFERRAL FORM
CENTRAL VALLEY HEALTH DISTRICT
Nursing Department
NURS 104 (10/2026)

Date:

REFERRING SOURCE	
Referring Person Name:	Telephone Number:
Agency (if applicable):	Fax Number (if applicable):

CLIENT INFORMATION			
Name:		Telephone Number:	
Address:	City:	State:	Zip Code:
Date of Birth:	Gender: ☐ FEMALE ☐ MALE	Has the client been informed of the available public health nursing services? ☐ YES ☐ NO	

MEDICAL HISTORY	
Physician:	Pharmacy:
Date of Discharge (if applicable):	Medications currently managed by:
Diagnosis (if applicable):	
Reason for Referral:	
Upcoming Appointments (Dates and Times):	

Please include the following documents with the referral form (if available):

☐ Recent medical history information & wellness visit summary ☐ Discharge summary and/or orders
☐ Current medications list signed by PCP ☐ Documentation of DNR status

OTHER AGENCIES AND SERVICES INVOLVED:

☐ Buffalo Bridges Social Services	Social Worker:			
☐ South Central Human Service Center	Case Manager:			
☐ Senior Center	☐ Transportation	☐ Meal Services	☐ Life Line	☐ Freedom Resource

DIGITAL FORM:
bit.ly/CVHDForms

Submit completed referral form and supporting documents to Kim Lee, RN by fax or email (kclee@nd.gov)