

(SEE PRIVACY ACT STATEMENT ON REVERSE)

COMMUNITY HEALTH NURSING – CASE REFERRAL

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

TO: (Name and location) Community Health Nursing Phone: 301-677-8434 / 8435 Fax: 301-677-8422		FROM: (Name and location)	
1. NAME OF PATIENT (Last, First, Middle Initial)		2. ADDRESS OF PATIENT (Give specific directions)	
3. DATE OF BIRTH	4. HOME PHONE		
5. NAME OF SPONSOR (Last, First, Middle Initial)			
6. GRADE AND SSN	7. OFFICE PHONE		
8. ORGANIZATION			
9. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION I hereby authorize the release of the medical information relevant to this referral to the _____ _____ _____ <i>Signature of Patient (or person authorized to consent for patient)</i> _____ <i>Date</i> _____			
10. REASON FOR REFERRAL; OTHER SIGNIFICANT DATA			
10.a. Blood lead level evaluation			
10.a.1. Blood lead level	10.a.2. Date of level	10.a.3. Previous blood lead levels and dates	
10.b. Lead education			
10.b.1. Handouts given? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," enter the date given and title(s).)			
10.b.2. Video viewed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," enter the date viewed and the title.)			
10.b.3. Is further lead education needed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10.c. Home evaluation			
10.c.1. Are there other children residing at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," enter their names and ages.)			
10.c.2. Are there any pregnant females residing at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," enter her/their name(s) and phone number(s).)			
10.c.3. Type of dwelling the family live in: <input type="checkbox"/> Apartment <input type="checkbox"/> Townhouse <input type="checkbox"/> Duplex <input type="checkbox"/> Single-family home <input type="checkbox"/> Mobile home			
10.c.4. How long has the family resided at this address?	10.c.5. The family lives in <input type="checkbox"/> On-post housing <input type="checkbox"/> Off-post housing		10.c.6. What year was the residence built?
10.d. Name of primary care provider			
10.e. Dates of follow up visits with the primary care provider			
11. SIGNATURE OF INITIATOR			12. DATE
13. LOCATION OF RECORDS (Check applicable box(es)) MEDICAL RECORDS <input type="checkbox"/> ARE <input type="checkbox"/> ARE NOT IN FILES OF THIS INSTALLATION. FAMILY RECORDS <input type="checkbox"/> ARE <input type="checkbox"/> ARE NOT IN FILES OF THIS INSTALLATION.			
This form in and of itself DOES NOT constitute a contract with the Army for payment of services to be rendered.			

14. REPORT OF FINDINGS AND RECOMMENDATIONS

15. SIGNATURE OF INDIVIDUAL COMPLETING ITEM 14.

16. DATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: 5 US Code 301; 10 US Code 1071; 42 US Code; 44 US Code 3101.
2. PRINCIPAL PURPOSE(S): Provides a means for medical and allied medical personnel to refer individuals and families for Army community health nursing services.
3. ROUTINE USES:
 - a. To refer patients or family units to other military and civilian health and welfare agencies or to Army community health nurses at other military installations.
 - b. A case referral which contains medical information requires written consent of the patient or legal representative prior to release to a civilian agency.
 - c. A doctor's signature is required when medication and/or treatments are ordered.
 - d. To provide continuity of care, minimize duplication of effort and furnish accurate information to other health care providers.
 - e. When case is completed or inactive, one copy of record is returned to the initiator (item 2, above) and duplicate copies of record are destroyed when no longer needed.
4. MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary, however, failure to provide information may prevent continuity of care, cause duplication of effort and prevent accuracy of information to other health care providers.