State of Hawaii
Health Department

Public Health
Nursing Branch

REQUEST FOR NURSING SERVICES

Date:

Client: Sex: BD:
Last Name First Name Middle

Ethnicity:
List All

School: Grade:

Home Address: Phone:
House No. Street Name City State Zip

Mailing Address: Other Phone:
If different from Home House No. or P.O. Box

Father:
Last First Middle BD Phone No(s)

Mother:
Last First Middle BD Phone No(s)

Email Address:

Other Contact Person: Relationship: Phone:

Medical Insurance: **Number:** Subscriber:
Name of Company / Plan

Primary Physician: Phone:

Other Physician: Phone:

Medical / Clinical Diagnosis:

Reason(s) for Referral: ____

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Significant Information: ____

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Planned Discharge Date: Hospital:

Other Agencies Involved or Referred To: **Contact Person:** Phone/Email:

______________________________ ____________________ ________________

Requested By: Title: Agency:

Address: ______________________________ Phone: ________________

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PHN SUMMARY: ____

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For PHN Office Use Only:

Date Rcvd:______________ By: CT: Assigned PHN: ________________

Currently Carried: No Yes By: Registration #:

Previously Carried by:

DISPOSITION: Admitted Disposition Letter Sent Date: Not Admitted

L Unlocated R Refused PHN Services C Assistance from Other Agency / Program

Other: