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: Name of Company / Plan _____ **Number:** _____ Subscriber: _____

Primary Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Medical / Clinical Diagnosis: _____

Reason(s) for Referral:

Significant Information:

Planned Discharge Date: _____ Hospital: _____

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

_____ _____ _____

_____ _____ _____

Requested By: _____ Title: _____ Agency: _____

Address: _____ Phone: _____

****

PHN SUMMARY:

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: