

Health Navigation Referral Tool

Fax 515.993.4949 Phone 515.993.3750 Scan & Email to PHN@dallascountyiowa.gov

Date: _____

Client Name: _____ DOB: _____

Phones: _____

Address: _____

Area of Need

- | | |
|---|--|
| <input type="checkbox"/> Access to Medical Care | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Maternal Child Health |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Medication Assistance |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Parenting/Childcare |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Food | <input type="checkbox"/> Support Group |
| <input type="checkbox"/> Health/Chronic Disease Education | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> Immunizations | |

Comments: _____

Referring Entity

Person Making Referral: _____ Organization: _____

Phone: _____

Has client been informed that you are making this referral? Yes No

Do you have a signed release of information on file? Yes No