

**Bay View Lutheran Church
Health & Wellness Ministry - Parish Nurse Program
Intake/Referral Form**

Date _____ Referral Source _____
(Self, Pastor, Family Member, Other)

Client Name _____ Phone :()- _____ - _____

Male: _____ Female _____ Marital Status: M W D S Sep

Living Arrangement: Living Alone__ with Spouse____ with Family____

CBRF__ NSG Home__ Adult Family Home __ Other _____

Identified Need: Home visit _____ Telephone call _____ Office call _____

Present Concerns/Reason for Referral:

Physical Condition (s)/Limitation(s)

Other Agencies, services involved in the home:

For Home Visiting Referrals:

Smoking in the home? Y__N__ Pets? Y__N__

Consent Form

It may be necessary for Bay View Parish Nurses to consult with other community resources regarding my needs.

Client Signature_____ Date_____

Family/Friend Contact:

Name_____ Relationship to Client_____

Address_____ Phone (____) - ____ - _____

Name_____ Relationship to Client_____

Address_____ Phone (____) - ____ - _____

Please Submit Referral to:

**Judy Neumann, RN, Parish Nurse or
Nancy Fauser, RN, Parish Nurse**