HENRY COUNTY HEALTH DEPARTMENT

1843 Oakwood Avenue
Napoleon, OH 43545

www.henrycohd.org
Phone: (419) 599-5545
Confidential Fax: (419) 591-3064

AGENCY CMH REFERRAL FORM

COMPLEX MEDICAL HELP PROGRAM

Submit completed form to Karen Engler, RN, at kengler@henrycohd.org or confidential fax number

Referring Agency: _____ Date: _____

Address: _____

Contact Person: _____ Phone: _____

Email address: _____ Fax: _____

Reason for referral: _____

_____

Is family aware of referral? (Circle one) **Yes** **No** **Unknown**

Name of Child(ren)	Sex	DOB	Race
_____	**M F**	_____	_____
_____	**M F**	_____	_____
_____	**M F**	_____	_____

Primary Care Physician: _____ Date of last visit: _____

Specialist(s): _____ Date of last visit(s): _____

Date Of upcoming visit: _____

Parent/Guardian/**Mother's** Name: _____ DOB: _____

Parent/Guardian/**Father's** Name: _____ DOB: _____

Parent/Guardian's Address: _____

Phone (Mother): _____ Phone (Father): _____

Email address: _____ Primary Language: _____

HCHD Office use only:

Assigned CMH Nurse: _____ Date Received: _____

Date of Initial Contact with Family: _____ Letter: _____Phone: ____ Visit: ____ HCHD/HV _____E-Mail _____