FREEBORN COUNTY Minnesota

Public Health Referral/Intake Form

Return completed form to: publichealth@co.freeborn.mn.us

Name of person needing services: _____ DOB: _____ Gender: _____

Address: _____ City: _____ Zip Code: _____ Phone: _____

Race: _____ Ethnicity: _____ May text: _____ May leave VM: _____

Primary language spoken: _____ Interpreter needed: _____

Best time to call: _____

Additional family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Additional comments:

Agency/person making referral, include phone: _____

Reason for Referral:

- ☐ Breastfeeding Consult
- ☐ Car Seat Education (no visit)
- ☐ Family Home Visiting *EDC _____
- ☐ WIC
- ☐ Elderly Waiver/Alternative Care
- ☐ Community Health Visit
- ☐ Healthy Homes (lice/bed bugs/lead/radon)
- ☐ Immunizations
- ☐ TB
- ☐ Perinatal Hep B
- ☐ Refugee Health

Submit Form