Elim Faith Community Nursing
A Ministry of Elim Care
SERVING IN THE SPIRIT OF CHRIST'S LOVE

PARISH NURSE REFERRAL

Office: *Cell:*
Email: *Website:*

Date				
Referral made by	Name	Organization	Phone	
Contact Information	Name		Phone	
	Address	City	State	Zip
Permission to Contact	Did this person agree to a follow-up contact by a FCNP member? ☐ Yes ☐ No			
Contact Preferences	Method: ☐ Phone call only ☐ Home visit ☐ Office visit ☐ Other location	Best day/time for visit: ☐ ____ a.m. ☐ ____ p.m. Priority: ☐ High ☐May be seen within 5-10 days		
Brief description of need				

FOR OFFICE USE ONLY		
Date received by Parish Nurse		
Team member assigned		
Follow-up action taken **(Use back of form if needed)**		
Referral source notified of visit:	Date	By whom
Referrals made to:	☐ Mental Health Worker ☐ Local pastor ☐ Local church ☐ Social Services ☐ Other	