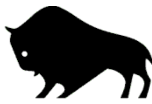
Manitoba 

Health

Interregional Referral for Public Health Service

Referred by: ______________________ **Phone #**_________________ **Date:** ______________

Received by: ______________________ **Phone #**_________________ **Date:** ______________

SITUATION:

Communicable disease: ____

Confirmed / Suspected: ____

(Attach lab report if available)

Client's identifying information:
Name: ____

DOB________________ PHIN # (or other Health # if not from MB) _________________________

Client's present location: ____
Client's permanent address: ____
Phone number(s): ____

BACKGROUND:

(What pertinent information is already known about the case (i.e. symptoms, clinical course, present status of the client – i.e. able to be interviewed or not; disposition of contacts from home and away from home). Has the Medical Officer of Health been notified by the Out of Region MOH?

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ASSESSMENT:

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Manitoba Health

REQUEST FOR FOLLOW UP: (Specifically what actions are you asking for and what is the time frame for theses actions?)

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Additional Information that may be required:

Family accompanying client: (Names, location, phone numbers)

Name	Relationship	Address	Contact #

Contacts that require follow-up:

Name	DOB	Address	Contact #