LOGAN HEALTH

Phone: 406-758-8488

Email: NHNReferrals@logan.org

NHN REQUEST FORM

Fill out this PDF form, Scan and email it to NHNReferrals@logan.org or fax to 406-758-3287. Contact us at (406) 758-8488 for any questions.

Date:_____

Requesting Clinic or Dept:_____ Requester Email:_____

Requester Name:_____ Requester Phone Number:_____

Client Information

Name:_____

Date of Birth:_____ Phone:_____ Alternate Phone:_____

Parent / Guardian Name (If client is under 18 yrs):_____

Home Physical Address:_____ Home City:_____

Current Location of client:_____

Primary Physician:_____

What time of day is best to call this client?_____

Community resources needed by the client:

- ☐ Child Resources
- ☐ End of Life Documents (Adv Directives, POA)
- ☐ Food Resources
- ☐ Health Coverage Info/Resources
- ☐ Home/Personal Care Information
- ☐ Housing Resources
- ☐ Legal Resources
- ☐ Long Term Care Information
- ☐ Social Security Disability (MT does not offer Short-Term Disability)
- ☐ Transportation Resources
- ☐ Utility Resources
- ☐ Veteran Resources
- ☐ Other (Please explain in the box below)

Check any/all that apply: __ Infectious Disease (Isolation period ends: _____), __ Mental Health Concern: (Meet in a public location), __ Family Dynamics (describe below), __ Pets (Must be contained), __ Smoking in the home.

Please include additional information about the client's current situation that would be helpful to the case.