MAGRUDER HOSPITAL

730 Jefferson Street
Port Clinton, OH 43452
PH 419-301-4304, opt 3 ◦ FAX 419-732-2864
communityhealthworker@magruderhospital.com

CLIENT INFORMATION	
Name:	DOB:
Address:	Race/Ethnicity:
City, State, Zip:	Phone #:
REFERRED BY	
Name:	Phone #:

PLEASE CHECK ALL RISK FACTORS THAT APPLY	
□ Alcohol / Substance Abuse	□ Legal
□ Asthma	□ Low Income
□ Childcare	□ Medication Assistance
□ Clothing	□ Obese
□ Depression or Other Mental Health Concern	□ Physically Inactive
□ Developmental Delay of Child in Family	□ Poor Diet
□ Domestic Violence	□ Smoker / Tobacco User
□ Education Assistance	□ Stress
□ Family HX of Child Abuse / Neglect or Involvement with CPS	□ Transportation
□ Family HX of Heart Disease / Diabetes	□ Other:
□ Financial Assistance	
□ Food	□ Child under age 18 living in the home
□ Housing	□ Pregnant Estimated due date: _____
□ Insurance	Gravida/Para: ____ / ____
□ Job / Employment	

Insurance Status: Include Copy of Card □ Medicaid □ Medicare □ Uninsured □ Private □ Unknown

Please provide any additional information that may be helpful: _____

_____

_____

_____

* By signing here, I consent for _____ (Referring Agency) to share the above information with the Northwest Ohio Pathways HUB for the purposes of enrollment into the Magruder Hospital Pathways Program.

Print Name: _____ Signature: _____ Date: _____

PLEASE FAX OR EMAIL REFERRAL