Faith Community Nurse Network
Of the Greater Twin Cities

Client/Family Information Form

Date: _____ Time: _____

Client/Family Name: _____

DOB: _____ Age/Age Range: _____ Gender: M F Marital Status: _____

Address:_____

Phone: **H:**_____ **W:**_____ **Other:**_____

Name:	Family/Significant Others:	Relationship:	Address:	Phone:

*Indicates emergency contact

Client Congregational Status (Circle): Member Non-member

Advanced Directives: Y N **Durable Power of Attorney for Health Care**: Y N

Funeral Planning: Y N Agent Name: _____Phone: _____

Primary Health Care Physician Name: _____Phone: _____

Other Health Care Professional Name: _____Phone: _____

Purpose of Contact: Spiritual_____Psychosocial_____Cancer_____Endocrine_____

Cardiovascular_____ Chronic Disease___ GU/Reproductive_____

Infectious Disease_____ Mental Health_____ Musculoskeletal_____ Neurological____

Pulmonary_____ Sensory_____ Health-seeking behavior_____

Safety/Environment_____ Financial_____ Other {specify} _____

Additional Information: _____

Parish Nurse Signature: _____

Congregation_____

Additional Information (each entry must be signed and dated):