



REFERRAL FORM
 Fax referral to
 386.238.9348
 Call Connect:
 386.238.9347

PARTICIPANT INFORMATION

Participant being referred (select one) <input type="radio"/> Pregnant Woman, Due Date: _____ <input type="radio"/> Infant (0-12 months) <input type="radio"/> Child <input type="radio"/> Mother / Interconception Woman (ICC): post-partum up to 36 months or had a loss <input type="radio"/> Other caregiver		Insurance Medicaid? <input type="radio"/> Yes <input type="radio"/> No ID#: _____ Private? <input type="radio"/> Yes <input type="radio"/> No ID#: _____		
First Name	Last Name	Date of Birth (mm/dd/yyyy)	Gender	SSN
Physical Address		City	State	ZIP Code
Main Phone	Other Phone	Email		
Authorized the following methods of contact (select all that apply): <input type="radio"/> Leave message in my voicemail <input type="radio"/> Leave message with the person answering my phone <input type="radio"/> Visit my home if unable to contact me <input type="radio"/> Send letters/correspondences to my home address <input type="radio"/> Text message <input type="radio"/> Email				

Preferred Language(s) <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other: _____	Race <input type="radio"/> White <input type="radio"/> Black/African-American <input type="radio"/> Multi/Biracial <input type="radio"/> American Indian OR Alaska Native <input type="radio"/> Asian/Pacific Islander	Ethnicity <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic
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****IF PARTICIPANT IS AN INFANT OR CHILD, PLEASE PROVIDE PARENT/GUARDIAN INFORMATION BELOW**

First Name	Last Name	Date of Birth (mm/dd/yyyy)	Relationship to Child
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RISK FACTORS (SELECT ALL THAT APPLY)

Pregnant Woman <input type="radio"/> First pregnancy <input type="radio"/> Teen mom <input type="radio"/> Incarcerated <input type="radio"/> Substance exposure: _____ <input type="radio"/> Tobacco use <input type="checkbox"/> Nicotine use <input type="checkbox"/> Vaping <input type="checkbox"/> Mother <input type="checkbox"/> Other member of household <input type="radio"/> Pregnancy interval less than 18 months <input type="radio"/> 2 nd trimester entry or no prenatal care <input type="radio"/> Fetal developmental delay <input type="radio"/> Prior poor birth outcomes <input type="checkbox"/> Had a baby not born alive <input type="checkbox"/> Had a baby born more than 3 wks before due date <input type="checkbox"/> Had a baby weighing less than 5 lbs 8 oz <input type="radio"/> Plan of Safe Care: Y / N <small>*Please note: HIV and Hepatitis B referrals will be accepted <i>but</i> require <u>written</u> consent from the participant</small>	Infant/Child <input type="radio"/> Low Birth Weight (less than 4 lbs, 7 oz) <input type="radio"/> Admitted to NICU <input type="radio"/> Substance exposure: _____ <input type="radio"/> Exposure: Tobacco <input type="checkbox"/> Nicotine <input type="checkbox"/> Vaping <input type="radio"/> Birth defect <input type="radio"/> Growth / developmental delay <input type="radio"/> Father is not involved <input type="radio"/> Plan of Safe Care: Y / N Mother / ICC <input type="radio"/> Child not in mother's guardianship <input type="radio"/> Growth / developmental delay <input type="radio"/> Pregnancy loss <input type="radio"/> Infant / child death <input type="radio"/> Depression <input type="radio"/> Plan of Safe Care: Y / N	Other Concerns or Needs <input type="radio"/> Domestic Violence (past or present) <input type="radio"/> Open dependency case; Case Number: _____ <input type="radio"/> Child placed for adoption <input type="radio"/> Other children under the age of 5 in the home <input type="radio"/> Death in immediate family <input type="radio"/> Homeless or unstable housing <input type="radio"/> Lack of other basic needs: _____ Food <input type="checkbox"/> Clothing <input type="checkbox"/> Transportation <input type="checkbox"/> Healthcare <input type="radio"/> Mental health (or history of): _____ i.e. depression / stress / anxiety / hopelessness <input type="radio"/> Chronic health problem / illness: _____ <input type="radio"/> Prescription medication needs <input type="radio"/> Environmental / occupational exposure: _____ <input type="radio"/> Lack of support <input type="radio"/> Military family <input type="radio"/> Prenatal / Post-partum Doula support
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ADDITIONAL COMMENTS/OTHER CONCERNS

CONSENT & REFERRING AGENCY INFORMATION

Verbally Signed Release of Information Signature Below

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect for one year from the date of signature until revoked in writing by me.

Parent/Guardian Signature _____	Date _____	Witness Signature _____	Date _____
Referring Person		Referring Agency	
Phone Number of Referring Agency	Fax Number of Referring Agency	Mailing Address of Referring Agency	