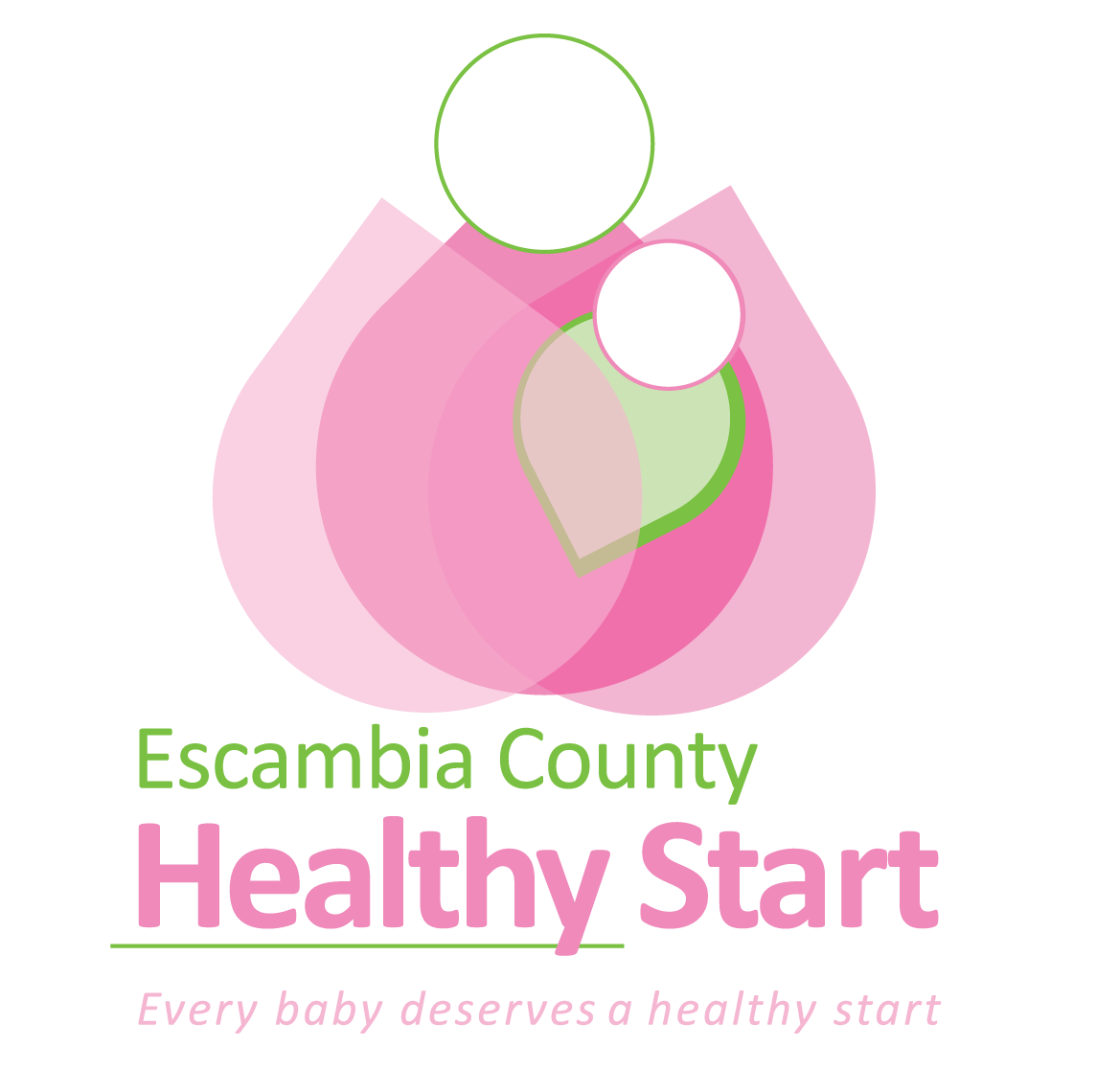
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Highlighted sections MUST be filled out for referral to be processed in a timely manner.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT INFORMATION** | | | | | | | | | | | | | | |
| **Patient being referred (select one):**   * Pregnant Woman, Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ * Infant (0-12 months) * Child (12-24 months) * Father * Other caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Woman without infant who is less than 18 months postpartum (ICC) | | | | | | | | | **Insurance (circle one):**   * Medicaid * Private * Tricare * No insurance | | | | | |
| **Patient First Name: Last Name:** | | | | | | **Date of Birth:**(mm/dd/yyyy) | | | | | | | **Gender:** | |
| **Address:** | | **Apt/Lot:** | | | **City** | | | | | **State:** | | | **Zip Code:** | |
| **Preferred Languages:** English Spanish Other: | | | | **Email:** | | | | | | | | | | |
| **Main Phone:** | **Other Phone:** | | | | | | | | | |  | | | |
| **\*\*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** |
| **RISK FACTORS (SELECT ALL THAT APPLY)** | | | | | | | | | | | | | | |
| **Mother:**   * First Pregnancy * Under the age of 18 * Incarcerated * Alcohol use during pregnancy * Substance exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Tobacco use * Pregnancy interval less than 18 months * 2nd trimester entry into prenatal care * No prenatal care * Current depression concerns * Prior pregnancy concerns   + Had a baby not born alive (miscarriage, stillborn)   + Infant loss   + Had a baby more than 3 weeks early.   + Had a baby weighing less than 5 lbs. 8oz   + History of Postpartum Depression * Chronic health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Mental Health Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Infant/Child:**   * Low Birth Weight (less than 4 lbs, 7 oz) * Admitted to NICU * Substance exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Tobacco exposure * Birth defect * Growth/ development delay * Father is not involved * Mother is not involved * No Safe Sleep Environment * Failure to Thrive * Open DCF case (provide details below) * Child placed for adoption * Child in foster care | | | | | | | | | **Family Concern or Needs**   * Other children under the age of 5 in the home * Death in the immediate family in last year * Homeless * Unstable housing * Lack of basic needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Lack of support * Military family * Financial Stress * Transportation Concerns * Needs Parenting Education * Single Parent * Father incarcerated * Substance use in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Family Violence within the last year | | |
| **ADDITIONAL COMMENTS** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **REFERRING AGENCY INFORMATION** | | | | | | | | | | | | | | |
| The client has consented to share the information on this form with and be contacted by CI&R. The client consents that information can be shared with one or more of the following collaborating agencies: Healthy Start Coalition of Escambia County, Healthy Families Florida and Escambia County Health Department for providing services. The client understands that this information will be confidential.   * **Verbal Consent Obtained Referring Person Name (print):** | | | | | | | | | | | | | | |
| **Date** | | | | | | | **Phone #:** | | | | | | | |
| **Referring Person Title:** | | | | | | | | | | | | **Referring Agency:** | | |
| **Email Address of referring person:** | | | | | | | | | | | | | | |



Additional Comments or Concerns: