****

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: