Referral Form

Fax to: (850) 696 -2551

Call Connect: (850) 696-2291

Email: referrals@healthystart.info

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 and to be contacted by CI&R

The client consents that information can be shared with one or more of the following collaborating agencies: Escambia County Healthy Start Coalition, 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: