Connect

Connecting families to community programs

Florida Healthy Start — Central Healthy Start | Healthy Start of North Central Florida

Maternal, Infant & Early Childhood Home Visiting Program

Healthy Families Florida

www.ConnectNCF.org

REFERRAL FORM

FAX THIS FORM TO 352-313-6513

Call Connect: 877-678-9355

CLIENT INFORMATION

Client (select one)

❍ Pregnant Woman Due Date_____

❍ Infant

❍ Interconceptional Woman (ICC) (Woman who had a loss or removal of infant within last 18 months.)

Insurance

Medical Insurance? ❍ Yes ❍ No

Medicaid ID #

First Name	Last Name	Date of Birth *(mm/dd/yyyy)*	Gender (if infant)

Physical Address	Apt	City	State	ZIP Code

Main Phone	Other Phone	Email	County

Preferred Language(s)

❍ English ❍ Spanish ❍ Creole

❍ Other_____

Race

❍ Black/African-American ❍ White

❍ Other_____

Ethnicity

❍ Hispanic ❍ Non-Hispanic

PARENT/GUARDIAN INFORMATION (IF CLIENT IS INFANT)

First Name	Last Name	Date of Birth *(mm/dd/yyyy)*	Relationship to Child

RISK FACTORS (SELECT ALL THAT APPLY)

Pregnant Woman

❍ First pregnancy
❍ Teen mom
❍ Substance exposure
❍ Tobacco use
  ❑ Mother
  ❑ Other member of household
❍ Pregnancy interval less than 18 months
❍ Prior poor birth outcomes
  ❑ Had a baby not born alive
  ❑ Had a baby born more than 3 weeks before due date
  ❑ Had a baby weighing less than 5 lbs, 8 oz

Infant

❍ Low Birth Weight (less than 4 lbs, 7 oz)
❍ Admitted to NICU
❍ Father is not involved
❍ Tobacco exposure
❍ Substance exposure
❍ Growth or developmental delay
❍ Chronic illness or health problem

ICC Woman

❍ Child not in mother's guardianship
❍ Pregnancy loss
❍ Infant death
❍ Child placed for adoption

Additional Concerns

❍ Domestic violence (past or present)
❍ Open dependency case
❍ Mental health (or history of): depression / stress / anxiety / hopelessness
❍ Other children under the age of 5 in the home
❍ Death in immediate family or child death
❍ Homeless or unstable housing
❍ Lack of support
❍ Incarcerated parent
❍ Military family
❍ Low family or student academic achievement

ADDITIONAL COMMENTS

REFERRING AGENCY INFORMATION

The client has consented to share the information on this form with and be contacted by **Connect**. The client consents that information can be shared with collaborating agencies. The client understands that this information will be confidential.

Verbal Consent Obtained By *(name)*	Date
Referring Agency	Referring Person
Phone Number of Referring Agency	Fax Number of Referring Agency