Connect

Connecting families to community programs

Florida Healthy Start | Nurse-Family Partnership | Healthy Families Florida

United Way Partner Agency

REFERRAL FORM

FAX (239)425-6921

Call Connect:
(239)425-6930

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	Gender (if infant)

Physical Address	Apt	City	State	ZIP Code
			Florida	

Main Phone	Another 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	Relationship to Child
			Mother

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	Date
Referring agency	Referring Person
Phone Number of Referring Agency	Fax Number of Referring Agency

Healthy Start of Southwest Florida www.healthystartbaby.org
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