Healthy Start
Strengthening Our Future HERE

Connect
Connecting families to community programs
connect@healthystartfv.org

REFERRAL FORM
Fax referral to 386.238.9348

Call Connect:
386.238.9347

PARTICIPANT INFORMATION

Participant being referred (select one)
❍ Pregnant Woman, Due Date: _____ ❍ Infant (0-12 months) ❍ Child
❍ Mother / Interconception Woman (ICC): post-partum up to 36 months or had a loss ❍ Other caregiver

Insurance
Medicaid? ❍ Yes ❍ No ID#: _____
Private? ❍ Yes ❍ No ID#: _____

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

Physical Address	City	State	ZIP Code

Main Phone	Other Phone	Email

Authorized the following methods of contact (select all that apply): ❍ Leave message in my voicemail ❍ Leave message with the person answering my phone
❍ Visit my home if unable to contact me ❍ Send letters/correspondences to my home address ❍ Text message ❍ Email

Preferred Language(s)
❍ English ❍ Spanish ❍ Other: _____

Race ❍ White ❍ Black/African-American ❍ Multi/Biracial
❍ American Indian OR Alaska Native ❍ Asian/Pacific Islander

Ethnicity
❍ Hispanic ❍ Non-Hispanic

**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)

Pregnant Woman
❍ First pregnancy ❍ Teen mom ❍ Incarcerated
❍ Substance exposure: _____
❍ Tobacco use
☐ Mother ☐ Other member of household
❍ Pregnancy interval less than 18 months
❍ 2nd trimester entry or no prenatal care
❍ Fetal developmental delay
❍ Prior poor birth outcomes
☐ Had a baby not born alive
☐ Had a baby born more than 3 wks before due date
☐ Had a baby weighing less than 5 lbs 8 oz
❍ Plan of Safe Care: Y / N ☐

*Please note: HIV and Hepatitis B referrals will be accepted *but* require written consent from the participant

Infant/Child
❍ Low Birth Weight (less than 4 lbs, 7 oz)
❍ Admitted to NICU
❍ Substance exposure: _____
❍ Tobacco exposure
❍ Birth defect
❍ Growth / developmental delay
❍ Father is not involved
❍ Plan of Safe Care: Y / N ☐

Mother / ICC
❍ Child not in mother's guardianship
❍ Growth / developmental delay
❍ Pregnancy loss ❍ Infant / child death
❍ Depression
❍ Plan of Safe Care: Y / N ☐

Other Concerns or Needs
❍ Domestic Violence (past or present)
❍ Open dependency case
❍ Child placed for adoption
❍ Other children under the age of 5 in the home
❍ Death in immediate family
❍ Homeless or unstable
❍ Lack of other basic needs: _____
☐ Food ☐ Clothing ☐ Transportation ☐ Healthcare
❍ Mental health (or history of): _____
i.e. depression / stress / anxiety / hopelessness
❍ Chronic health problem / illness: _____
❍ Prescription medication needs
❍ Environmental / occupational exposure: _____
❍ Lack of support ❍ Military family
❍ Prenatal / Port-partum Doula support

ADDITIONAL COMMENTS/OTHER CONCERNS

CONSENT & REFERRING AGENCY INFORMATION

❍ Verbally ❍ Signed Release of Information ❍ Signature Below

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect for one year from the date of signature until revoked in writing by me.

_____ _____
Parent/Guardian Signature Date Witness Signature Date

Referring Person		Referring Agency
Phone Number of Referring Agency	Fax Number of Referring Agency	Mailing Address of Referring Agency