Connect

Connecting families to community programs

Escambia County Healthy Start

HEALTHY FAMILIES FLORIDA

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:

Correspondence allowed: *Email *Phone *Text *Voicemail *Home Visit * US Mail *Secure Messaging App

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
  - 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
- 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
- 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: Escambia County Healthy Start Coalition, Healthy Families Florida, Children's Home Society and Florida Department of Health in Escambia County 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 or Fax Number of referring person:	

Additional Comments or Concerns: