Referral Form

Client Information

Referral Date _____ Client Name (First, Last, M.I.) _____DOB _____

Phone Number (____)_____ Medicaid Number_____ Preferred Language _____

Address_____ City_____ State_____ Zip_____

Race ☐ Black/African American ☐ White ☐ Other _____ Hispanic ☐ YES ☐ NO

Type of Referral

____Prenatal Referral

Due Date _____

First Time Mom ☐ YES ☐ NO

____Infant Referral

Infant Gender ☐ F ☐ M

Parent/Care givers name _____

Parent/Care givers DOB _____

Relationship to infant _____

Reason for Referral

Mother

☐< 18 years old
☐Substance Abuse
☐Second Trimester or no Prenatal Care
☐Chronic Condition
☐Pregnancy interval < 18 months
☐Had a baby born 3 weeks or more before due date
☐Had a baby weighing less than 5 lbs. 8 oz
☐Had a baby not born alive

Infant

☐Low birth weight (less than 2000 grams/ 4lbs. 7oz
☐Admitted to NICU
☐Positive for substance

Other Factors

☐Open Investigation with DCF
☐Child not in mother's guardianship
☐Other_____
_____

_____ **ICC Referral** *(Interconceptional care is for clients who are not pregnant and have experienced a fetal/infant loss, have had an infant removed from the home, or have placed an infant up for adoption)*

Client's youngest child's age _____

Fetal/ Infant Loss ☐ Infant Removed from Home ☐ Mother has made a life plan for the infant ☐

Additional Comments:

Referring From/ Title _____***Phone***_____

Referring Agency _____ ***Email*** _____

Connect Okaloosa-Walton
Phone (850) 833-3999 (Options 1 & 6) | Fax (850) 833-9484