Connect

Connecting families to community programs

Coordinated Intake and Referral Form

Fax: 850-833-9484 Phone: 850-833-3999

Client Information

Select one:
☐Pregnant Woman ☐Doula Care
☐Infant
☐Interconception Woman (ICC)

Medical Insurance:
Yes ☐ No ☐ **Insurance:** _____
Medicaid ID#:
Doctor:

Mother's First Name:	**Mother's Last Name:**	**Mothers Date of Birth: (mm/dd/yyyy)**	**Married:** ☐ Yes ☐ No
Infant's First Name:	**Infant's Last Name:**	**Infants Date of Birth: (mm/dd/yyyy)**	**Gender of Infant:** ☐Female ☐Male

Address:	**Apt:**	**City**	**State:**	**Zip Code:**

Preferred Languages: ☐ English ☐Spanish ☐Other: _____

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

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐ Multiethnic ☐ Other: _____

Race: ☐ White ☐ Multiracial ☐ Black/African American ☐ Other: _____

Main Phone:	**Other Phone:**	**Due Date: (mm/dd/yyyy)**	**Weeks Pregnant:**

Risk Factors (Fill out all applicable)

Mother:
☐No Prenatal Care
☐Began Prenatal Care in 2nd or 3rd trimester
☐First Pregnancy
☐Less than 18 years of age
☐Smoked cigarettes in the last month
☐Depressed/Stress/Anxiety
☐Pregnancy Interval less than 18 months
☐Lacking basic needs (food, home, clothes)
☐Had a baby not born alive
☐Infant death
☐Had a baby more than 3 weeks before due date
☐Had a baby weighing less than 5lbs, 8 oz.
☐Mental Health concerns
☐Child adopted
☐Substance exposure Substance: _____

Infant:
☐Low birth weight (less than 2000 grams/ 4lbs. 7oz)
☐Admitted to NICU
☐Father is not involved
☐Positive for substances Substance: _____
☐Child not in mother's guardianship
Guardian's Name: _____
Guardian's Phone: _____
☐Died

Additional Factors
☐Other children under the age of 6 in the home
☐Has a Special Needs household member
☐Domestic Violence
☐Trouble paying bills
☐Undesired pregnancy
☐Open DCF case

Additional Comments

Referring Agency Information

The client has consented to share the information on this form with and be contacted by Connect (CI&R). The client consents that information can be shared with one of more of the collaborating agencies: Healthy Start Coalition of Okaloosa and Walton counties, Healthy Families of West Florida, Military New Parent Support Program, and Florida Department of Health in Okaloosa and Walton counties. The client understands that this information will be confidential.

Client's Verbal Consent Obtained ☐	**Date:**
Referring Person Name/Title:	**Referring Agency:**
Email Address:	**Phone:**

Healthy Start Okaloosa-Walton

HEALTHY FAMILIES FLORIDA

New Parent Support Program "Healthy Families on Track"