Connect Families + Resources

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
☐ **Medicaid ID#: Doctor:** **Insurance:** _____

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: _____

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

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

I, _____ agree to share information with Connect, Healthy Start and Healthy Families personnel to discuss services and community resources through phone calls, texts, emails, or home visits. _____(sign & date)

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

Healthy Start Okaloosa and Walton Counties

HEALTHY FAMILIES FLORIDA

New Parent Support Program "Healthy Families on Track"