Healthy Start

REFERRAL FORM

Referred to: Florida Department of Health in Miami-Dade County, Healthy Start Data Management Office		
Address: 18255 Homestead Avenue, Miami, Florida 33157	**Phone**: (305) 278-1074	**Fax**: (305) 234-2263
From: (name of person making the referral)	**Title**:	**Cell Phone**:
Organization:		
Phone:	**Fax:**	**Mailing Address:**

CLIENT AND FAMILY INFORMATION

Client: (check one) ___ **Pregnant Woman** ___ **Infant** ___ **Interconception Woman (ICC)**	**First Name:** **Last Name:** **Date of Birth:** (mm/dd/yyyy)		**Medical Insurance?** ___ Yes ___ No **Medicaid ID #** **Social Security #**
Mother's First and Last Name (if client is an infant)		**Mother's Date of Birth** (if client is an infant) (mm/dd/yyyy)	**Home Phone**
Address (street address, apartment #, city, state, zip code)			**Cell Phone**
Race: (please circle) Black - White - Hispanic - Other	**Are you married?** ___ YES ___ NO	**Number of weeks of pregnancy:**	**Doctor's Name:**
Language of Preference: (please circle) English - Spanish - Creole Other: _____	**Do you have a support system?** ___ YES ___ NO	**Estimated Delivery Date (EDD):** Month ____ Day ____ Year ____	**Next Doctor's Appointment Date:** Month ____ Day ____ Year ____

MOTHER'S RISKS: ___ Age is 17 or younger ___ Education is less than 12th grade ___ Someone hit/hurt mother in the last year ___ No prenatal care or started care at 14th week or more ___ Pre-pregnancy BMI less than 19.8 or more than 35.0 ___ Has a chronic health condition ___ Substance use in the last month ___ Smoked cigarettes in the last month ___ First pregnancy (1st time mom) ___ Does not want pregnancy ___ Reported mental health concerns ___ Depression/Hopelessness/Stress ___ Homelessness	**IF NOT FIRST PREGNANCY**: ___ Pregnancy interval less than 18 months ___ Had a baby that was not born alive ___ Had a baby born more than 3 weeks before due date ___ Had a baby weighing less than 5lbs,8oz **ICC WOMAN REFERRAL:** ___ Pregnancy Loss ___ Infant death ___ Child adopted ___ Child not in mother's guardianship ___ Other	**INFANT'S RISKS**: **GENDER:** Male_____ Female _____ ___ Abnormal condition ___ Birth weight is less than 2000 grams (4lbs,7oz) ___ Admitted into neonatal intensive care unit ___ Transferred to another facility ___ Principal source of payment Medicaid ___ Father's name not present or unknown ___ Mother used tobacco in one or more trimesters ___ Prenatal visits less than 2 or unknown ___ Maternal age 17 or younger

Client's Consent: I accept the invitation to participate in Florida's Healthy Start Program. I consent that this information be given to the County Health Department, Healthy Start providers, and Healthy Start Coalition of Miami-Dade and shared with its programs: HealthConnect In The Early Years, MomCare, Nurse Family Partnership, and Jasmine Project for services. I understand that this information will be held strictly confidential.

Please check all appropriate boxes below authorizing the HEALTHY START PROGRAM OF FLORIDA staff to contact you:

1. Leave messages in my voicemail ___ YES ___NO
2. Visit my home if unable to contact me ___ YES ___NO
3. Send an Email message ___ YES ___NO
4. Leave messages with the person answering the phone ___ YES ___ NO
5. Send letters/correspondences to my home address ___ YES ___ NO
6. Send a Text/SMS message ___ YES ___ NO

Email Address: _____

_____ _____

Signature of Client or Parent/Guardian **Date** **Referring Person's Signature** **Date**

Referral Comments: