

## Healthy Start Referral Form

Today's Date:	REFERRING AGENCY/ORGANIZATION:		
Referral From:	Title:	Cell:	
Phone:	Fax:	Mailing Address:	

### MOTHER INFORMATION

* Last Name:	* First:	* Middle:	* D.O.B	* Race: Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Creole <input type="checkbox"/> Other <input type="checkbox"/>
*Address:				
*City:	*Zip code:	*Home phone:	*Cell:	
Is client married? Yes <input type="checkbox"/> No <input type="checkbox"/>		Expected Due Date:	Best time to call:	

### REASON FOR REFERRAL (Check all that apply)

<input type="checkbox"/> Teen mom (18 and under)	<input type="checkbox"/> Someone hit/hurt mother in the last year	<input type="checkbox"/> Had baby that was not born alive
<input type="checkbox"/> 2 <sup>nd</sup> Trimester entry or no prenatal care	<input type="checkbox"/> Postpartum depression	<input type="checkbox"/> Had baby born 3 weeks or more before due date
<input type="checkbox"/> Pregnancy interval <18 months	<input type="checkbox"/> Reported depression/hopelessness/stress	<input type="checkbox"/> Had baby weighing less than 5 lbs 8 oz
<input type="checkbox"/> Has chronic medical condition	<input type="checkbox"/> Homelessness	
<input type="checkbox"/> Substance use/Smoked cigarettes in the last month	<input type="checkbox"/> Other reason, specify :	

### INFANT INFORMATION

* Last Name:	* First:	* Middle:	* D.O.B	* Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
* Address:			* Social Security #:	
* City:	* Zip code:	* Home phone:	* Cell:	

### REASON FOR REFERRAL (Check all that apply)

<input type="checkbox"/> Poor birth outcome	<input type="checkbox"/> Infant birth weight is less than 2000 grams (4 lbs 7 oz)	<input type="checkbox"/> Infant admitted to NICU	<input type="checkbox"/> Mother smoked/Substance use during pregnancy (exposed)	<input type="checkbox"/> Bonding concerns
<input type="checkbox"/> Depression	<input type="checkbox"/> Parenting stress	<input type="checkbox"/> Lack of resources	<input type="checkbox"/> Other reason, specify :	

### CLIENT AUTHORIZED THE FOLLOWING METHOD OF CONTACT (Check all that apply)

<input type="checkbox"/> Leave message in my voicemail	<input type="checkbox"/> Leave message with the person answering my phone	<input type="checkbox"/> Visit my home if unable to contact me	<input type="checkbox"/> Send letters/correspondences to my home address
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\* Fields must be completed

This form contains confidential client information and all HIPAA procedures need to be followed.

Send Referrals to: DOH/Healthy Start Program 475 W Story Rd Suite 1, Ocoee FL 34761 or

Fax to 407-845-6122;

Call 407-858-1472 to confirm receipt of referral