Connect
Connecting families to community programs

Healthy Start Coalition of Jefferson, Madison, and Taylor Counties

To submit this referral, you may:
Fax it to 850-948-3072
E-mail it to:
eschmidt@healthystartjmt.org

CLIENT INFORMATION

Client (select one) **Case ID**_____

❍ Pregnant Woman Due Date_____
❍ Infant
❍ Interconceptional Woman (ICC) (Woman who had a loss or removal of infant within last 18 months.)

Insurance
Medical Insurance? ❍ Yes ❍ No
Medicaid ID #

First Name	Last Name	Date of Birth *(mm/dd/yyyy)*	Gender (if infant)

Physical Address	Apt	City	State	ZIP Code

Main Phone	Other Phone	Email	County

Preferred Language(s)
❍ English ❍ Spanish ❍ Creole
❍ Other_____

Race
❍ Black/African-American ❍ White
❍ Other_____

Ethnicity
❍ Hispanic ❍ Non-Hispanic

PARENT/GUARDIAN INFORMATION (IF CLIENT IS INFANT)

First Name	Last Name	Date of Birth *(mm/dd/yyyy)*	Relationship to Child

RISK FACTORS (SELECT ALL THAT APPLY)

Pregnant Woman
❍ First pregnancy
❍ Pregnant teen
❍ Substance use
  ❑ History ❑ Current
  ❑ Other member of household
❍ Tobacco use
  ❑ History ❑ Current
  ❑ Other member of household
❍ Pregnancy interval less than 18 months
❍ Prior poor birth outcomes
  ❑ Had a baby not born alive
  ❑ Had a baby born more than 3 weeks before due date
  ❑ Had a baby weighing less than 5 lbs, 8 oz

Infant
❍ Low Birth Weight (less than 4 lbs, 7 oz)
❍ Admitted to NICU
❍ Father is not involved
❍ Tobacco exposure
❍ Substance exposure
❍ Growth or developmental delay
❍ Chronic illness or health problem

ICC Woman
❍ Child not in mother's guardianship
❍ Pregnancy loss
❍ Infant death
❍ Child placed for adoption

Additional Concerns
❍ Domestic violence (past or present)
❍ Open dependency case
❍ Mental health (or history of):
  depression / stress / anxiety / hopelessness
❍ Other children under the age of 5 in the home
❍ Death in immediate family or child death
❍ Homeless or unstable housing
❍ Lack of support
❍ Incarcerated parent
❍ Military family
❍ Low family or student academic achievement
❍ Teen parent

Additional Concerns:

REFERRING AGENCY INFORMATION

The client has consented to share the information on this form with and be contacted by **Connect**. The client consents that information can be shared with collaborating agencies. The client understands that this information will be confidential.

Verbal Consent Obtained By *(name)*	Date

Referring Agency	Referring Person

Phone Number of Referring Agency	Fax Number of Referring Agency	Email Address of Referring Agency

Supervisor	Email	Date