Connect

Connecting families to community programs

Coordinated Intake and Referral Form

Fax: 850-747-5435 Phone: 850-527-3745

Client Information

Select one:
- ❑ Pregnant Woman
- ❑ Infant
- ❑ Interconception Woman (ICC)

Medical Insurance: Yes No
Insurance: **Social Security#:**
Medicaid ID#:
Provider Name:

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:		**Email:**	
Ethnicity: Hispanic Non-Hispanic Multiethnic Other:		**Race:** Black/African-American White Multiracial Other:	
Main Phone:	**Other Phone:**	**Due Date: (mm/dd/yyyy)**	**Weeks Pregnant:**

Methods of Contact Preferred (circle all that apply): Call Text Message Voicemail Mail Home Visit

Risk Factors (Fill out all applicable)

Mother of Infant:
- ❑ Began Prenatal Care in 2nd or 3rd trimester
- ❑ First Pregnancy
- ❑ Less than 18 years of age
- ❑ Smoked cigarettes in the last month
- ❑ Depressed/Stress
- ❑ Pregnancy Interval less than 18 months
- ❑ Lacking basic needs (food, home, clothes)
- ❑ Had a baby not born alive
- ❑ Had a baby more than 3 weeks before due date
- ❑ Had a baby weighing less than 5lbs, 8 oz.
- ❑ Mental Health concerns
- ❑ Infant death
- ❑ 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

Additional Comments

Referring Agency Information

The client has consented to share the information on this form with and be contacted by CI&R. The client consents that information can be shared with one or more of the following collaborating agencies: Bay, Franklin, Gulf Healthy Start Coalition, Healthy Families Florida, Early Education & Care, Parents As Teachers and the Children's Advocacy Center for providing services. The client understands that this information will be confidential.

❑ **Verbal Consent Obtained** **Date:**

Verbal Consent Obtained by (print):	**Phone #:**
Referring Person Title:	**Referring Agency:**
Email Address:	**Address of Referring Agency:**

GulfCoast Children's Advocacy Center — Protecting Children, Strengthening Families
Healthy Families Florida
Healthy Start — Coalition of Bay, Franklin & Gulf Counties
Parents as Teachers Affiliate
Early Education and Care, Inc.
Florida Health