Broward Healthy Start Coalition, Inc.

REFERRAL FORM FOR HEALTHY START PROVIDERS

Please Print or Write Legibly

Date: _____

Agency Referred To:	
Address:	Area Code & Telephone Number:

From (name of person making referral):	Title:	Area Code & Telephone Number:
Agency:		
Address:		

Last Name of Participant:	**First** Name of Participant:	Middle Init:	Date of Birth:	SS #/ ID #
Area Code and Telephone Number:	Address:	City:		Zip Code
Parent/Guardian's Name:	Date of Birth	SS #/ ID #		Medicaid Number:
Name of Health Care Provider:	Area Code &Telephone #:	Mailing Address and City:		

Reason for Referral – Risk Factors:

Prenatal Referral

- ☐ Pregnant Teen: Name of School _____
- ☐ Age <18 or >39
- ☐ <12th grade or GED
- ☐ Prenatal weight < 110#
- ☐ Household hunger
- ☐ Poor pregnancy timing
- ☐ Poor pregnancy outcome
- ☐ Race Black or unknown
- ☐ Not married
- ☐ Can't keep appointments
- ☐ High stress
- ☐ Tobacco use
- ☐ Alcohol or other drug use
- ☐ Chronic medical condition
- ☐ Moved > 3 times in 12 months
- ☐ Entry into prenatal care 2nd trimester or later
- ☐ Feels unsafe where living
- ☐ Other: Indicated below ☐ or Please call: ☐

Comments:

Postnatal Referral: ☐ Infant 0-1 ☐ Child 1-3

- ☐ Parenting Teen: Name of School _____
- ☐ Mother's age is <18 or unknown
- ☐ Mother is over 18 **and** mother's education < 12th grade or unknown
- ☐ Mother not married
- ☐ Mother's race unknown or non-white
- ☐ No prenatal care
- ☐ Birth weight < 2,000 grams (4 lbs. 7 oz.)
- ☐ Tobacco Use during pregnancy
- ☐ Alcohol use during pregnancy
- ☐ Congenital anomalies
- ☐ Abnormal health conditions of newborn
- ☐ Drug use during pregnancy
- ☐ Other: Indicated below ☐ or Please call: ☐

_____ **Infant's Healthy Start Screening Score**

_____
Referring Person's signature Date

EDD Date: _____ **LEVEL OF PARTICIPANT** _____ **OR** ☐ Prior to Initial Contact **MEDICAL CONSENT IN FILE: Y**____ **N** ____

Consent:

I accept the invitation to participate in Florida's Healthy Start Program. If yes, or maybe, I give permission for this information to be given to the Broward Healthy Start Coalition and its designated care coordination agencies or to the following agency _____. I understand that this information will be held strictly confidential.

Acepto la invitación para participar en el Programa Healthy Start de Florida (Comienzo Saludable). Si acepto, o si creo que voy a aceptar, doy mi autorización para compartir esta información con la Coalición de Healthy Start de Broward y también con las agencias designadas para coordinar los servicios de Healthy Start o la siguiente agencia _____. Entiendo que esta información se mantendrá en estricta confidencialidad.

☐ Yes/ Sí ☐ No ☐ Maybe/Quizá

_____ _____
Signature of Participant or Parent/Guardian (Firma del cliente o guardian) Date (Fecha)

Revised June 2004

Distribution: ☐ Original to Referred Agency
☐ Copy to Participant Record
☐ Copy to Healthy Start