HSHHP Coordinated Intake and Referral Form

Agency Use Only

Name of Person Making Referral: ______ Date of Referral: ______

Referring Agency: ______ Phone Number of Referring Agency: ______

Participant Information

First Name: ______ Last Name: ______

DOB: ______ Phone Number: ______

Address 1: ______

Address 2: ______

City: ______ State: ______ Zip Code: ______

Primary Language: ______ EDD:

Relationship to Child (check one): ☐ Mother ☐ Father ☐ Pregnant ☐ Other (please specify): ______

Child Information

Child's First Name: ______ Child's Last Name: ______

Child's DOB: ______ M F

Are there other children in the home? ☐ Yes ☐ No

Name of other children (if known): ______

DOB of other children (if known): ______

Reason for Referral

Reason for Referral (select all that apply):

- ☐ Basic prenatal education
- ☐ First time parent
- ☐ Teen parent
- ☐ Pre-mature birth
- ☐ Unemployed
- ☐ No HS diploma/GED
- ☐ TANF/Medicaid eligible
- ☐ Homeless or unstable housing
- ☐ Limited Knowledge of child development
- ☐ Childbirth education & support
- ☐ Lactation counseling
- ☐ Nutrition counseling
- ☐ Parenting education & support
- ☐ School Readiness
- ☐ Tobacco use in home
- ☐ Substance use past or present
- ☐ Domestic violence past or present
- ☐ Child w/ suspected developmental delay or chronic health problems
- ☐ Parent w/ disabilities or chronic health problems
- ☐ Parent with mental illness
- ☐ Involved with protective services
- ☐ Incarcerated parent
- ☐ Court appointed legal guardian or foster care
- ☐ Death in immediate family
- ☐ Military family
- ☐ Immigrant/refugee family (within 5 yrs)
- ☐ Other (please explain): ______

Encrypted email to: ginger.williams@flhealth.gov or **FAX:** 863-534-7046 Mail: 1290 Golfview Ave, 4th Floor, Bartow 33830

Referred by: ______ Email: Client Signature: ______