



**Bay, Franklin & Gulf Counties Coordinated Intake and Referral Form**

**Fax: (850) 747-5435**

Client Information					
<b>Select one:</b> <input type="checkbox"/> Pregnant Woman <input type="checkbox"/> Infant <input type="checkbox"/> Interconception Woman (ICC)	<b>Medical Insurance:</b> Yes    No <b>Insurance:</b> _____ <b>Social Security#:</b> _____ <b>Medicaid ID#:</b> _____ <b>Provider Name:</b> _____				
<b>Mother's First Name:</b> _____	<b>Mother's Last Name:</b> _____	<b>Mothers Date of Birth:</b> (mm/dd/yyyy)		<b>Married:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Infant's First Name:</b> _____	<b>Infant's Last Name:</b> _____	<b>Infants Date of Birth:</b> (mm/dd/yyyy)		<b>Gender of Infant:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Address:</b> _____	<b>Apt:</b> _____	<b>City:</b> _____	<b>State:</b> _____	<b>Zip Code:</b> _____	
<b>Preferred Languages:</b> English    Spanish    Other: _____			<b>Email:</b> _____		
<b>Ethnicity:</b> Hispanic    Non-Hispanic    Multiethnic    Other: _____			<b>Race:</b> Black/African-American    White    Multiracial    Other: _____		
<b>Main Phone:</b> _____	<b>Other Phone:</b> _____	<b>Due Date:</b> (mm/dd/yyyy)		<b>Weeks Pregnant:</b> _____	
<b>Methods of Contact Preferred (circle all that apply):</b> Call    Text Message    Voicemail    Mail    Home Visit					
Risk Factors (Fill out all applicable)					
<b>Mother of Infant:</b> <input type="checkbox"/> Began Prenatal Care in 2 <sup>nd</sup> or 3 <sup>rd</sup> trimester <input type="checkbox"/> First Pregnancy <input type="checkbox"/> Less than 18 years of age <input type="checkbox"/> Smoked cigarettes in the last month <input type="checkbox"/> Depressed/Stress <input type="checkbox"/> Pregnancy Interval less than 18 months <input type="checkbox"/> Lacking basic needs (food, home, clothes) <input type="checkbox"/> Had a baby not born alive <input type="checkbox"/> Had a baby more than 3 weeks before due date <input type="checkbox"/> Had a baby weighing less than 5lbs, 8 oz. <input type="checkbox"/> Mental Health concerns <input type="checkbox"/> Infant death <input type="checkbox"/> Child adopted <input type="checkbox"/> Substance exposure    Substance: _____			<b>Infant:</b> <input type="checkbox"/> Low birth weight (less than 2000 grams/ 4lbs. 7oz) <input type="checkbox"/> Admitted to NICU <input type="checkbox"/> Father is not involved <input type="checkbox"/> Positive for substances    Substance: _____ <input type="checkbox"/> Child not in mother's guardianship <i>Guardian's Name:</i> _____ <i>Guardian's Phone:</i> _____ <input type="checkbox"/> Died <b>Additional Factors</b> <input type="checkbox"/> Other children under the age of 6 in the home <input type="checkbox"/> Has a Special Needs household member <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Trouble paying bills <input type="checkbox"/> 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.					
<input type="checkbox"/> <b>Verbal Consent Obtained</b> <b>Date:</b> _____					
<b>Verbal Consent Obtained by (print):</b> _____				<b>Phone #:</b> _____	
<b>Referring Person Title:</b> _____			<b>Referring Agency:</b> _____		
<b>Email Address:</b> _____			<b>Address of Referring Agency:</b> _____		

