PASCO CONNECT
EMPOWERING FAMILIES

Community Referral Form

DATE:_____

1. Please advise all potential **at-risk** participants that services are provided free of charge and 100% voluntary for parents who are expecting a baby or have a child under the age of 3 years.
2. Pasco connect will connect parents to a program in which they can learn about prenatal care, immunizations, well-baby care, breastfeeding, nutrition, child development, parenting, smoking cessation, interconception care, community resources, and more.
3. **Send ENCRYPTED Email or FAX this form to: 727-841-6555**
   If you have any questions, please contact Morgan at 727-203-5239 - mneff@healthystartcoalitionpasco.org or Ingrid (**Spanish speaker**) at 727-371-6277 - idefillo@healthystartcoalitionpasco.org.

REFERRAL MADE BY:

Name/Title: _____

Phone/Email: _____

Agency/Program: _____

Reason for Referral: _____

_____

- □ Abnormal conditions (NICU, assisted ventilation, illness
- □ Age <18
- □ Domestic Violence (past or present)
- □ First time mom
- □ Fetal Demise
- □ Growth/development delay
- □ Late/No entry into prenatal care
- □ Last pregnancy complications (high risk)
- □ Low birth weight 2,000 g or less that 4lbs 7oz.
- □ Medical Condition □HIV □HepB
- □ Mental Health
- □ Nutrition/Weight Issues
- □ Other children younger than 5 □Medical/special needs?
- □ Pregnancy interval less than 18 months
- □ Sexual Abuse (past or present)
- □ Substance use/abuse
- □ Smoking cessation
- □ Other:

CLIENT INFORMATION **Client Type:** ☐ Prenatal ☐ Infant

Mother/Guardian's Name: _____ D.O.B: _____

Address: _____

City/Zip: _____Phone: _____Language: _____

Mother/Guardian's Email:_____

Married: ☐ Yes ☐ No Race: _____ Pregnancy #: _____ Estimated Due Date: _____

CHILD'S INFORMATION

Child's Name: _____ D.O.B of child (if Infant): _____

Gestational Age _____ Type of Deliv: _____ ☐Male ☐Female

My signature below indicates my consent to be contacted by Pasco Connect for enrollment into a program, such as Healthy Start or Healthy Families

Parent/Guardian Signature:_____ Date: _____

HEALTHY FAMILIES PASCO-HERNANDO

HEALTHY START COALITION Pasco County

Florida HEALTH Pasco County