Miami-Dade County
Coordinated Intake and Referral Form
Fax To: (786) 565-4013 OR Email to: referrals@hscmd.org

Florida Healthy Start
Healthy Start Coalition of Miami-Dade

Client Information

Client (select one): _ Pregnant Woman _ Infant _ Interconception Woman (ICC)	Insurance: Medical Insurance? Yes No Medicaid ID#: Social Security#

First Name:	Last Name:	Date of Birth:	Gender (if infant):

Mother Information (if client is infant)

First Name:	Last Name:	Date of Birth:

Additional Information

Physical Address:	Apt:	City:	State:	Zip Code:

Preferred Language(s): English Spanish Creole Other:	Email:
Ethnicity: Hispanic Non-Hispanic	Race: Black/African-American White Other

Main Phone:	Other Phone:	Due Date:	Weeks Pregnant:

Risk Factors (select all the apply)

Pregnant Woman:
- ☐ First Pregnancy
- ☐ Teen mom
- ☐ Substance exposure
- ☐ Smoked Cigarettes in the last month
- ☐ Depression/Hopelessness/Stress
- ☐ Pregnancy Interval less than 18 months
- ☐ Lacking basic needs (food, home, clothes)
- ☐ Had a baby not born alive
- ☐ Had a baby born more than 3 weeks before due date
- ☐ Had a baby weighing less than 5 lbs, 8 oz

Infant:
- ☐ Low Birth Weight (less than 2000 grams/4lbs.7oz)
- ☐ Admitted to NICU
- ☐ Father is not involved

ICC Woman:
- ☐ Child not in mother's guardianship
- ☐ Pregnancy loss
- ☐ Infant Death
- ☐ Child adopted

Other children in the home? Yes No	Children under the age of 5 in the home? Yes No

Additional Comments

Referring Agency Information

The client has consented to share the information on this form with and be contacted by Coordinated Intake and Referral using the identified methods below. The client consents that information can be shared with one or more of the following collaborating agencies: Jasmine Project, Healthy Families, Healthy Start Coalition of Miami Dade, Nurse-Family Partnership and County Health Department, for providing services. The client understands that this information will be confidential.

Verbal Consent Obtained by *(name)*:	Date:
Referring Agency:	Referring Person:
Phone number of Referring Agency:	Fax number of Referring Agency:

Client consents to the following contact methods: ☐ Phone ☐ Mail ☐ E-Mail ☐ Text Message ☐ Home Visit

The Jasmine Project
HEALTHY FAMILIES FLORIDA
HEALTHY START
Nurse-Family Partnership
Helping First-Time Parents Succeed