Healthy Start
Coalition of Hillsborough County

We can **CONNECT** you to services.

REFERRAL FORM

Call: (813) 307-8016
Fax: (813) 307-8052
Email: connect@hstart.org

CLIENT INFORMATION

Client (select one)
☐ Pregnant Woman Due Date_____
☐ Infant
☐ Woman who had a loss or removal of infant within the last 18 months (ICC)

Insurance
Medical Insurance ☐ Yes ☐ No

Medicaid ID # _____

First Name	**Last Name**	**Date of Birth** *(mm/dd/yyyy)*	**Gender** *(if infant)*

Physical Address	**Apt #**	**City**	**State**	**Zip**

Main Phone	**Other Phone**	**Email**	**County**

Preferred Language(s)
☐ English ☐ Spanish ☐ Creole
☐ Other _____

Race
☐ Black/African American ☐ White
☐ Other _____

Ethnicity
☐ Hispanic
☐ Non-Hispanic

PARENT/GUARDIAN INFORMATION (IF CLIENT IS INFANT)

First Name	**Last Name**	**Date of Birth** *(mm/dd/yyyy)*	**Relationship to Child**

REASON FOR REFERRAL

☐ Domestic Violence
☐ Child Abuse/Neglect
☐ Substance Abuse
☐ Sexual Abuse
☐ Known History of Abuse
☐ Diagnosed Mental Illness

☐ Inadequate Growth & Development
☐ Safety Concerns noted on provider screen
☐ Mother age: 10 – 14 15 – 19
☐ Teen aging out of foster care
☐ Medical Conditions
☐ Other: _____

ICC Woman
☐ Child not in mother's guardianship
☐ Pregnancy loss
☐ Infant death
☐ Child placed for adoption

ADDITIONAL COMMENTS

REFERRING AGENCY INFORMATION

The client has consented to share the information on this form with, and to be contacted by, **Connect**. The client consents that information can be shared with collaborating agencies. The client understands 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**	**Email**