COMMUNITY CONNECT REFERRAL FORM

Please FAX completed form to (321) 634-6108

If you have questions about Community Connect or any of the home visiting programs and resources please contact us at: (321) 634-6101 or email: connect@healthystartbrevard.com

Community Connect
Connecting families with the resources they need

Community Connect will connect families with local resources and services in the community. We will guide them to home visiting programs like Healthy Families, Healthy Start, Nurse Family Partnership, Early Head Start, and additional resources in our community that can help support their family.

Date: ____/____/____ ☐Community Referral ☐Self Referral

Name of person making referral: _____ Contact number: (_____)_____

Agency: ☐ BFP ☐ DCF ☐ BHA Other:_____ Fax: (_____)_____

Position: _____ Email: _____

HOME VISITING PROGRAM MENTIONED TO CLIENT:

☐ Healthy Families ☐ Healthy Start ☐ Nurse Family Partnership ☐ Early Head Start ☐ Other _____

PRIMARY CAREGIVER DEMOGRAPHICS

☐Mother ☐Father ☐Other _____

Last Name: _____ First Name: _____

DOB: ____/____/____ ☐Homeless / ☐Transition

Address: _____City/State/Zip: _____

Cell Phone: (____)_____ Alternate Phone: (____)_____ Best time: AM/PM _____

Best Way to Contact? ☐Phone ☐Text ☐Email:_____

Primary Language Spoken: ☐English ☐Spanish ☐Other, Specify: _____

Medical insurance? ☐Medicaid, Specify:_____ Medicaid #_____ ☐Private ☐No insurance

Presently involved in a home visiting program? ☐Yes, Program: HS, HF, Other-Specify: _____ ☐No

☐ **PRENATAL:** Mother's EDD: ____/____/____

☐ **POSTNATAL:** Baby(ies)'s First Name: _____ Baby(ies)'s Last Name: _____
Baby's DOB: ____/____/____ Is / was your child in the NICU? ☐Yes ☐No Date came home ____/____/____

REASON(S) FOR REFERRAL (Check all that Apply)

☐ 1. Late or no prenatal care
☐ 2. High Risk Pregnancy
☐ 3. Substance Abuse: History_____ Current_____
☐ 4. Domestic Violence: History_____ Current_____
☐ 5. Mental Health: History_____ Current_____
☐ 6. First Time Mother
☐ 7. Medical Issues:_____
☐ 8. Involvement in Dependency System
☐ 9. Concerns with Bonding and Attachment
☐ 10. Concerns with Infant Development
☐ 11. Infant tested positive
☐ 12. Lack of Support
Other: _____

Notes:

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CITD ID# _____ ☐ **Client Declined Services**

Verbal Consent Obtained: ☐Yes ☐No Client verbally acknowledged consent and understanding.

CC Signature: _____ Date: ____/____/____

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