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 an 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

CONSENTED COMMUNICATION STYLE (Must be completed in order to contact)

☐ Correspondence Allowed ☐ Mail ☐ Email ☐ Phone ☐ Text Message
☐ Leave Voicemail ☐ Leave Message ☐ Home Visit ☐ Secure Messaging Apps

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**