Date: ______________________

From: ____ **Agency:** ________________________________

Infant/Child's Name being referred: ____
Date of Birth: ________________ Race: _______________ Primary Language: ___________________
Place of birth: _________________________ Gestational Age: _______ Birthweight: _______________
NICU Admission: Yes No Medical Insurance: ____
Healthcare Provider(s): ____________________________ Specialist(s): ____________________________
Safety Concerns: ____
____
Health Concerns/Abnormal Conditions: ____
____
Father involved: Yes No Other Children in the home: Yes No Is yes, ages: ____________________
Parent/Guardian Name of Infant/Child being referred: ____
Date of Birth: _________________ Phone: ____
Street Address: __________________________ City: _____________________ Zip Code: ___________

Pregnant Woman's Name being referred: ____
Date of Birth: ________________ Race: _______________ Primary Language: ___________________
Place of birth: ____________ Married: Yes No Father involved: Yes No
1st Pregnancy: Yes No Trimester Care began: _______ EDD: _________________
Medical Insurance: ___________________________ Healthcare Provider: ___________________________
Other Children in the home: Yes No Is yes, ages: ____
Primary Phone: ______________________________ Secondary Phone: _____________________________
Street Address: __________________________ City: _____________________ Zip Code: ___________
Tobacco Use? Yes No UnK Alcohol Use? Yes No UnK Drug Use? Yes No UnK
Safety Concerns: ____
____
Health Concerns: ____
____
Other Concerns/Details: ____
____

Charlotte County
CONNECT/HEALTHY START
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Port Charlotte, FL 33953 Phone:
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(941) 347-6466