Parents as Teachers® Affiliate

Maternal, Infant & Early Childhood Home Visiting Program

MIECHV/PAT

This program is supported by the Florida Maternal, Infant and Early Childhood Visiting Initiative.

MIECHV REFERRAL FORM

SEND ENCRYPTED EMAIL OR FAX TO THE MIECHV OFFICE IN YOUR COUNTY:

ALACHUA COUNTY: Kids Central, Inc.
PHONE: 352-203-0628 FAX: 352-337-2800
EMAIL: Kasey.Brooks@KidsCentralinc.org

MARION COUNTY: Kids Central, Inc.
PHONE: 352-789-4397 FAX: 352-387-3546
EMAIL: Yisel.Romero@KidsCentralinc.org

BRADFORD, COLUMBIA, HAMILTON AND PUTNAM COUNTIES:
UF Department of Obstetrics and Gynecology, College of Medicine
PHONE: 352-294-5521 FAX: 352-294-5533
EMAIL: mgharris@ufl.edu

OR SEND ENCRYPTED EMAIL TO CONNECT@WELLFLORIDA.ORG

PHONE: 877-678-9355

PARTICIPANT INFORMATION

Parent/Caregiver Name	Date of Birth *(mm/dd/yyyy)*	Gender

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

Child's Name	Date of Birth *(mm/dd/yyyy)*	Gender

Main Phone	Other Phone	Email	County

Home Address	Apt	City	State	ZIP Code

Mailing Address	Apt	City	State	ZIP Code

FAMILY STRESSOR (SELECT ALL THAT APPLY)

- ❍ Low income
- ❍ Teen parent
- ❍ Low educational attainment
- ❍ Child abuse or neglect
- ❍ Substance abuse
- ❍ Tobacco use in the home
- ❍ Military family
- ❍ Children or parent with developmental delays, disabilities or chronic health issues
- ❍ Parent with mental illness
- ❍ Recent immigration or refugee family
- ❍ Court appointed legal guardian or foster care
- ❍ Homeless or unstable housing
- ❍ Incarcerated parents
- ❍ Very low birth weight (< 3.3 lbs.)
- ❍ Death in immediate family
- ❍ Intimate partner violence

REFERRING AGENCY INFORMATION

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

MIECHV/PAT RESPONSE TO REFERRAL

Enrolled in MIECHV	Parent Educator's Name
❍ Yes ❍ No	