



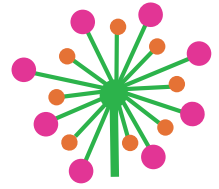
MIECHV REFERRAL FORM

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

ALACHUA COUNTY: Kids Central, Inc.
PHONE: 352-337-1200 **FAX:** 352-337-2800
EMAIL: Kasey.Brooks@KidsCentralinc.org

MARION COUNTY: Kids Central, Inc.
PHONE: 352-547-3730 **FAX:** 352-387-3546
EMAIL: Kasey.Brooks@KidsCentralinc.org

BRADFORD, COLUMBIA, HAMILTON AND PUTNAM COUNTIES:
 UF Department of Obstetrics and Gynecology, College of Medicine
PHONE: 352-273-7588 **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) <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Creole <input type="radio"/> Other		Race <input type="radio"/> Black/African-American <input type="radio"/> White <input type="radio"/> Other		Ethnicity <input type="radio"/> Hispanic <input type="radio"/> 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)

- | | |
|---|---|
| <input type="radio"/> Low income
<input type="radio"/> Teen parent
<input type="radio"/> Low educational attainment
<input type="radio"/> Child abuse or neglect
<input type="radio"/> Substance abuse
<input type="radio"/> Tobacco use in the home
<input type="radio"/> Military family
<input type="radio"/> Children or parent with developmental delays, disabilities or chronic health issues | <input type="radio"/> Parent with mental illness
<input type="radio"/> Recent immigration or refugee family
<input type="radio"/> Court appointed legal guardian or foster care
<input type="radio"/> Homeless or unstable housing
<input type="radio"/> Incarcerated parents
<input type="radio"/> Very low birth weight (< 3.3 lbs.)
<input type="radio"/> Death in immediate family
<input type="radio"/> 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 <input type="radio"/> Yes <input type="radio"/> No	Parent Educator's Name
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