Pediatrician Referral Form

Pediatrician Name: _____ Practice Name:_____

Practice Address: _____

Practice Phone Number: _____

Patient Information

Infant's Name: _____ DOB:_____ SS#:_____
(First) (Last) (if known)

Caregiver's Name: _____ DOB:_____ SS#:_____
(First) (Last)

Address: _____ Apt #:_____

City: _____ State: _____ Zip:_____ Phone Number_____

Reason for Referral

❑ Lack of Support System ❑ Infant Loss ❑ High Stress Level

❑ Homeless ❑ Low Birth Weight ❑ Domestic Violence

❑ Use of Drugs/Alcohol and in need of the Women's Intervention Specialist (WIS) ❑ Financial Difficulties

❑ Medical Condition _____

❑ Other Concerns_____

Consent for Release of Information
Florida law requires that information contained in medical and/or client records be held in strict confidence and is not to be released without written authorization. The authorization you sign on this page will remain in effect for two years from today's date or until you/or your children no longer require services from Healthy Start or Healthy Families. You have the right to withdraw your authorization at any time.

I, _____, authorize _____
(Medical Provider Name, Address, and Phone Number)

_____

to disclose to Healthy Start / Healthy Families information contained on this referral form and receive follow-up information from Healthy Start / Healthy Families.

_____ _____ _____ _____
Signature of Caregiver Date Staff Requesting Information Date

My signature below indicates that I would like to be contacted by the Healthy Start Program.

_____ _____
Signature of Caregiver Date

Please complete and fax to the Healthy Start Assessment Center at: 386.947.2468
3875 Tiger Bay Rd., Daytona Beach, FL 32124 386.254.1226