

Florida Keys Healthy Start Coalition



Monroe County Resident Referral Form

Instructions to health care provider: Please indicate which of our many services your client will need more information on when they return home. Please fax to our secure fax line and we will contact the client so that the referred appropriate services are continued in Monroe County. Thank you for assisting our Florida Keys families. If the referral is urgent, please call our office at 305-293-8424.

Secure fax line: 305-293-8542

Agency	Service	Check for referral/Notes
Florida Keys Healthy Start 305-293-7516	Maternity, postpartum and newborn care support services	
WIC Programs 305-293-1742 Key West 305-289-2718 Marathon 305-853-3241 Tavernier	Women Infant and Children nutrition program	
Children's Medical Services 305-289-2779	Special health care needs, chronic, medical	
Easter Seals 305-294-1089	Medical rehabilitation, speech, occupational, physical therapy, and audiology screening	
Early Steps Program 305-294-1089	Developmental delays, early intervention	
Wesley House 305-809-5000 1-877-595-5437 (toll free)	Child care services, foster / adoption program, parenting, intervention and prevention services	
Healthy Families Monroe 305-293-7494	Home visiting program parenting/child interaction	
Monroe County Health Dept. 305-293-7500 Key West 305-289-2708 Marathon 305-853-3240 Tavernier	Immunizations, Healthy Start program regional offices	
Breastfeeding, support, pumps, information 305-293-8424	Program with support and free or lower cost pumps and products for special situations	
New mom support groups 305-293-8424 Key West 305-852-3601 Upper Keys	Mother to mother support with the challenges of parenting	

Official Use Only
Date/Initials

Rec'd _____

Ref _____

F/U _____

Health Care Provider Signature _____ Title _____
 Date _____ Hospital/Birth Center _____ Phone _____

I hereby grant release of my information to the Florida Keys Healthy Start Coalition which may contain medical or personal information for the purpose of receiving services which will benefit myself and/or my newborn baby. All services are voluntary, and I understand that I may need to provide more information to receive services.

Patient Signature: _____ Date: _____
 Mother Name _____ Father Name _____
 Monroe County Physical Address _____
 Parent telephone number _____ cell _____ wk _____
 Infant Name _____ Infant DOB _____