



CradleME is open to all birthing families in Maine!

Sign up for more information

Please complete this CradleME form and FAX to: **(207) 287-4577**

Call us with questions at: **1-888-644-1130**

FAMILY INFORMATION

*Information Required

Who should be contacted about the CradleME services?

*Your First and Last Name: _____ *Your Date of Birth: ____ / ____ / ____ Estimated due date: ____ / ____ / ____

Relationship to Child: Mom Dad Kin Placement Non-Kin Placement Guardian/Foster Parent Adoptive Parent Other _____

Interpreter needed? yes no If yes, language needed: _____ Has WIC

*Best Phone to Contact You: (____) _____ OK to text? yes no Alternate Phone Number: (____) _____

*Mailing Address: _____ Town: _____ Zip Code: _____

*Home Address: _____ Town: _____ Zip Code: _____

Primary Health Care or Prenatal Provider Name: (____) _____ Primary Health Care or Prenatal Provider Phone: (____) _____

*Your Baby's First and Last Name: _____ *Your Baby's Date of Birth: ____ / ____ / ____ Boy Girl First Child

For twins, triplets, etc., please write babies' names here: _____

Baby's Doctor: _____ Doctor's Phone: (____) _____

What types of information or supports might be helpful for your family?

- Requesting WIC referral
- Having a healthy pregnancy
- Caring for and feeding my baby
- Parenting support
- Connections to other parents or community resources
- Answers to questions about my or my baby's health

Yes, please connect me with Public Health Nursing and/or Maine Families. I would like to get a phone call to hear about the free services that are available for my baby and me.

I have been given a copy of this request for information.

I understand that this signature does not authorize the release of confidential health information. I will be asked to sign a release of my confidential health information by the servicing provider before any confidential information will be shared.

Signature

Date

Printed name

CONNECTING ORGANIZATION: PLEASE COMPLETE

*Organization: _____ * Name: _____ * Phone: (____) _____



CradleME Request PAGE 2: FOR HEALTH CARE PROVIDER USE ONLY(REQUIRED)

Information on Page 2 is submitted to Public Health Nursing only. Please submit an organizational release form along with a discharge summary for mom and baby.

To complete this CradleME request, please fill out Page 2 below and send both pages to CradleME by FAX: 207-287-4577. All eligible families who sign up for CradleME will be referred to a Maine Families visitor, Public Health Nurse, or both, based on the information that you provide below. **Please disregard the different text formatting styles below- These are intended for use by CradleME staff in sorting and directing referrals to the appropriate services based on family needs.**

Prenatal Woman	Postpartum Woman	Newborn or Infant
<p>Name: _____ DOB: _____</p> <p><input type="checkbox"/> WELL-PREGNANCY AND PARENTING SUPPORT AND EDUCATION</p> <p>Any health concerns? Please check all that apply below:</p> <p><input type="checkbox"/> Accident or injury in pregnancy</p> <p><input type="checkbox"/> Chronic health condition</p> <p><input type="checkbox"/> Complications of pregnancy: Fetal or placental</p> <p><input type="checkbox"/> Complication of pregnancy: Maternal</p> <p><input type="checkbox"/> Developmental disability or physical handicap</p> <p><input type="checkbox"/> Diabetes in pregnancy</p> <p><input type="checkbox"/> Emergency Department follow-up during pregnancy</p> <p><input type="checkbox"/> Fetal surveillance that supplements care by OB provider</p> <p><input type="checkbox"/> Hypertension disorders of pregnancy</p> <p><input type="checkbox"/> Medications requiring nursing assessment of the medication regime (dose, side effects, compliance) and the condition for which it was prescribed:</p> <p>_____</p> <p><input type="checkbox"/> Missed prenatal visits or late onset of care</p> <p><input type="checkbox"/> Multi-fetal gestation</p> <p><input type="checkbox"/> Other health-related risk factors affecting pregnancy—Please specify: _____</p> <p><input type="checkbox"/> Preterm labor or contractions</p> <p><input type="checkbox"/> Tobacco use</p> <p><input type="checkbox"/> Psycho-social* issues, if known—Please specify: _____</p>	<p>Name: _____ DOB: _____</p> <p><input type="checkbox"/> PARENTING AND INFANT CARE SUPPORT AND EDUCATION</p> <p>Any health concerns? Please check all that apply below:</p> <p><input type="checkbox"/> Abnormal bleeding or discharge</p> <p><input type="checkbox"/> Complications of labor, birth or postpartum</p> <p><input type="checkbox"/> Developmental disability or physical handicap</p> <p><input type="checkbox"/> Other specific health conditions that require nursing assessment and follow up—Please specify: _____</p>	<p>Name: _____ DOB: _____</p> <p><input type="checkbox"/> INFANT FEEDING SUPPORT AND EDUCATION</p> <p><input type="checkbox"/> Breastfeeding</p> <p><input type="checkbox"/> Breast & Bottle</p> <p><input type="checkbox"/> Bottle</p> <p>Any health concerns? Please check all that apply below:</p> <p><input type="checkbox"/> Birth Weight: _____</p> <p><input type="checkbox"/> Discharge Weight: _____</p> <p><input type="checkbox"/> Birth defects that may impact feeding or development, or requiring specialized care</p> <p><input type="checkbox"/> Birth injuries</p> <p><input type="checkbox"/> Child welfare involvement</p> <p><input type="checkbox"/> Diagnosed with a disorder through newborn screening</p> <p><input type="checkbox"/> Failure to thrive</p> <p><input type="checkbox"/> Infant feeding difficulty with challenges (other than just breastfeeding)</p> <p><input type="checkbox"/> Intrauterine growth restriction</p> <p><input type="checkbox"/> Newborn extended stay (>4 days)</p> <p><input type="checkbox"/> NICU admission or discharge</p> <p><input type="checkbox"/> Other specific health conditions that require nursing assessment and follow up—Please specify: _____</p> <p>_____</p> <p><input type="checkbox"/> Respiratory distress syndrome</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Sepsis</p> <p><input type="checkbox"/> Tobacco use</p> <p><input type="checkbox"/> Psycho-social* issues: Family environment</p>

*Examples of psycho-social issues: Lack of support/isolation; family stress or difficulties coping; housing or food insecurity; child welfare involvement; family hx of violence/conflict
 Have you referred this patient or family to any other home health nursing or parent support services? Please Specify: _____

PERSON SUBMITTING THIS FORM – Name: _____	Phone/Email: _____
Provider/Agency Name: _____	Floor/Unit: _____