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

*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:** ____

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