



## CradleME is a Connection to Supporting Services and Resources

Available to all Pregnant and/or Parenting Individuals and Families in Maine

Please complete this form  
Call us with questions at: 1-888-644-1130  
FAX to: (207) 287-4577

|                                                                                                                                                                                    |                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Parents First and Last Name:                                                                                                                                                       | Date of Birth:  |
| Estimated Due Date:                                                                                                                                                                | Discharge Date: |
| Relationship to Child: <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Kin Placement <input type="checkbox"/> Guardian/ Foster/ Resource Parent |                 |
| Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, language needed:                                                                              |                 |
| Phone Number: _____ Other Phone or e-mail: _____ Ok to text? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                              |                 |
| Mailing Address: _____ Town: _____ Zip Code: _____                                                                                                                                 |                 |
| Home Address: _____ Town: _____ Zip Code: _____                                                                                                                                    |                 |
| Parent's Health Care or Prenatal Provider Name:                                                                                                                                    | Phone:          |

|                                           |                |                                                                                              |
|-------------------------------------------|----------------|----------------------------------------------------------------------------------------------|
| Child(s) First Last Name:                 | Date of Birth: | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other |
|                                           |                | <input type="checkbox"/> First Baby?                                                         |
| Child(s) First Last Name:                 | Date of Birth: | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other |
|                                           |                | <input type="checkbox"/> First Baby?                                                         |
| Child's Health Care Provider Name: _____  |                | Phone: _____                                                                                 |
| Child's Anticipated Discharge Date: _____ |                |                                                                                              |

### CradleME services and supports

If you want to receive a call or text to learn more about the services listed below, check any or all boxes:

- |                          |                                                                                                                                                                                                                                                                                                                                   |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <b>Public Health Nursing:</b> Provides in person or virtual education, assessment, and breastfeeding support during your pregnancy and after birth to ensure the health of the family and infant, as well as provide coordination of care with community resources, and referrals. Our nurses are Certified Lactation Counselors. |
| <input type="checkbox"/> | <b>WIC Nutrition Program:</b> A supplemental nutrition program for Women, Infants, and Children offering complete nutrition care, including healthy food benefits, breastfeeding support, and referrals.                                                                                                                          |
| <input type="checkbox"/> | <b>Early Intervention for ME:</b> A statewide system of early intervention services for infants and toddlers (birth through age 3) with developmental delays or diagnosed conditions that may lead to future developmental delays, and their families. Free/voluntary.                                                            |
| <input type="checkbox"/> | <b>MaineMOM Services:</b> Pregnancy and postpartum healthcare with substance use recovery services.                                                                                                                                                                                                                               |

**You will also receive a call or text from Maine Families Home Visiting Program.** All people who are pregnant or families with a newborn can have support from the Maine Families Home Visiting Program. Maine Families Visitors can meet in-person or virtually and help with parenting, supporting your child's development, and the day-to-day challenges of family life.

If you **do not** want a call or text from Maine Families, check this box: ☐

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

☐ Verbal Permission has been received

☐ Family First Prevention- (OCFS use only-include ROI) Case ID \_\_\_\_\_

### REFERRING ORGANIZATION: PLEASE COMPLETE

\*Organization: \_\_\_\_\_ \*Name: \_\_\_\_\_ \*Phone: \_\_\_\_\_

## CradleME Request PAGE 2

For Public Health Nursing fill out page 2 & send with Page 1 by FAX 207-287-4577

**Suggested documents:** please include a release of information form along with supporting office notes or discharge summary for mom and baby when available. If any health concern is noted below, please consider checking off the public health nurse support box on page 1.

| Prenatal Needs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Postpartum Needs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Infant or Child Needs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| <b>Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>DOB:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>DOB:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>DOB:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Accident or injury in pregnancy</li> <li><input type="checkbox"/> Behavioral / mental health-related risk factors Please specify: _____</li> <li><input type="checkbox"/> Child welfare involvement</li> <li><input type="checkbox"/> Emergency Department follow-up during pregnancy</li> <li><input type="checkbox"/> Missed prenatal visits or late onset of care</li> <li><input type="checkbox"/> Fetal surveillance that supplements care by OB provider</li> <li><input type="checkbox"/> Medications requiring nursing assessment of the medication regime (dose, side effects, compliance) and the condition for which it was prescribed.</li> <li>_____</li> <li><input type="checkbox"/> Chronic health condition</li> <li><input type="checkbox"/> Complications of pregnancy: Fetal or placental</li> <li><input type="checkbox"/> Complications of pregnancy: Maternal</li> <li><input type="checkbox"/> Developmental or physical disability</li> <li><input type="checkbox"/> Diabetes in pregnancy</li> <li><input type="checkbox"/> Hypertension disorders of pregnancy</li> <li><input type="checkbox"/> Multi-fetal gestation</li> <li><input type="checkbox"/> Preterm labor or contractions</li> <li><input type="checkbox"/> Substance Use Disorder</li> <li><input type="checkbox"/> Tobacco Use</li> <li><input type="checkbox"/> Marijuana/Cannabis use</li> <li><input type="checkbox"/> Alcohol use disorder</li> <li><input type="checkbox"/> Other health-related risk factors affecting pregnancy. Please specify: _____</li> <li><input type="checkbox"/> Psycho-social issues*, please specify: _____</li> </ul> | <p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal bleeding or discharge</li> <li><input type="checkbox"/> Behavioral / mental health-related risk factors Please specify: _____</li> <li><input type="checkbox"/> Child welfare involvement</li> <li><input type="checkbox"/> Chronic health condition</li> <li><input type="checkbox"/> Complications of labor, birth or postpartum</li> <li><input type="checkbox"/> Developmental or physical disability</li> <li><input type="checkbox"/> Substance Use Disorder</li> <li><input type="checkbox"/> Tobacco Use</li> <li><input type="checkbox"/> Marijuana/Cannabis use</li> <li><input type="checkbox"/> Alcohol Use Disorder</li> <li><input type="checkbox"/> Other Please specify: _____</li> <li><input type="checkbox"/> Psycho-social issues*, please specify: _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Plan of Safe Care Completed <ul style="list-style-type: none"> <li><input type="checkbox"/> Substance Exposed/Affected Infant*</li> <li><input type="checkbox"/> Child welfare involvement</li> <li><input type="checkbox"/> FAS (Fetal Alcohol Syndrome)*</li> <li><input type="checkbox"/> Neonatal Abstinence Syndrome*</li> <li><input type="checkbox"/> NICU admission or discharge</li> </ul> </li> </ul> <p>Other health concerns, check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breastfeeding</li> <li><input type="checkbox"/> Breast &amp; Bottle</li> <li><input type="checkbox"/> Bottle</li> <li><input type="checkbox"/> Birth Weight:</li> <li><input type="checkbox"/> Discharge Weight:</li> <li><input type="checkbox"/> Birth Defects that may impact feeding or development, or requiring specialized care*</li> <li><input type="checkbox"/> Birth injuries*</li> <li><input type="checkbox"/> Diagnosed with a disorder through newborn screening*</li> <li><input type="checkbox"/> Failure to thrive*</li> <li><input type="checkbox"/> Infant feeding difficulty with challenges (other than just breastfeeding) *</li> <li><input type="checkbox"/> Intrauterine growth restriction*</li> <li><input type="checkbox"/> Newborn extended stay (&gt;4 days)</li> <li><input type="checkbox"/> Prematurity &lt;29 weeks*</li> <li><input type="checkbox"/> Respiratory distress syndrome*</li> <li><input type="checkbox"/> Seizures*</li> <li><input type="checkbox"/> Other specific health conditions that require nursing assessment and follow up. Please specify: _____</li> </ul> <p>*Is an existing condition of risk-automatically eligible for Early Intervention for ME-consider checking box on page 1</p> |

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\*Organization: \_\_\_\_\_ \*Name: \_\_\_\_\_ \*Phone: \_\_\_\_\_

