



CradleME is a Connection to Supportive Services

Available to all Birthing Families in Maine

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

Who should be contacted about this CradleME Request Form?

**Information Required*

*Your First and Last Name: _____

*Your Date of Birth: _____ Estimated Due Date: _____ Anticipated Discharge Date: _____

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

Interpreter Needed? Yes No If yes, language needed: _____

*Best Phone to Contact You: _____ Ok to text? Yes No

Alternate Phone Number: _____ Ok to text? Yes No

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

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

Parent's Primary Health Care or Prenatal Provider

Name: _____ Phone: _____

Child(s) First and Last Name: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> First Baby?

Child's Health Care Provider or Doctor

Name: _____ Phone: _____ Anticipated Discharge Date: _____

What type of support might be helpful for your family? (See informational handout for list of services)

- WIC Nutrition Program:** A supplemental nutrition program for Women, Infants and Children offering complete nutrition care, including healthy food benefits, breastfeeding support and referrals.
- Maine Families Visitor:** Provides in-person/virtual support and information to families expecting a new baby or with a newborn about parenting, supporting your child's development, and the day-to-day challenges of family life.
- Public Health Nurse:** Provides education, assessments, 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.
- Child Developmental Services/Early Intervention Program:** Provides free developmental screenings and/or evaluations and coordinates early intervention services for eligible infants/toddlers (birth through age 2) and their families.
- MaineMOM Services:** Pregnancy and postpartum healthcare and recovery services.

Yes, I would like to receive a phone call about the services and supports indicated above.

- I understand that my signature on this form 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.
- I have been given a copy of this request form.

 Signature Date Printed Name

Verbal Permission has been received

REFERRING ORGANIZATION: PLEASE COMPLETE

*Organization: _____ *Name: _____ *Phone: _____

To Add Other Documents/Attachments **CLICK HERE**

To email your request form **CLICK HERE**

CradleME Request PAGE 2

For Public Health Nursing fill out Page 2 & send **with Page 1** by FAX to 207-287-4577 or **email here**

Include a release of information form along with supporting office notes or discharge summary for mom and baby.

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

REFERRING ORGANIZATION: PLEASE COMPLETE

*Organization: _____ *Name: _____ *Phone: _____

To Add Other Documents/Attachments **CLICK HERE**

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