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 cradleme.mecdc@maine.gov**
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:	☐ Male ☐ Female ☐ First Baby?
Child's Health Care Provider or Doctor	Anticipated Discharge Date:	
Name:	Phone:	

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 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 **cradleme.mecdc@maine.gov**

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:**
☐ WELL-PREGNANCY AND PARENTING SUPPORT ANDEDUCATION Other health concerns, check all that apply: ☐ *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*** ☐ *Preterm labor or contractions* ☐ *Other health-related risk factors affecting pregnancy. Please specify:*	☐ PARENTING AND INFANT CARE SUPPORT AND EDUCATION Other health concerns, check all that apply: ☐ *Abnormal bleeding or discharge* ☐ *Complications of labor, birth or postpartum* ☐ ***Developmental disability or physical handicap*** ☐ *Other specific health conditions that require nursingassessment and follow-up Please specify:*	☐ INFANT FEEDING SUPPORT AND EDUCATION ☐ Breastfeeding ☐ Breast & Bottle ☐ Bottle ☐ Child Welfare Prevention *(Internal Use Only)* Other health concerns, check all that apply: ☐ 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 thanjust breastfeeding)* ☐ *Intrauterine growth restriction* ☐ *Newborn extended stay (>4 days)* ☐ *NICU admission or discharge* ☐ *Respiratory distress syndrome* ☐ *Seizures* ☐ *Sepsis* ☐ *Other specific health conditions that require nursing assessment and follow up. Please specify:*
☐ Tobacco use ☐ Psycho-social issues*, please specify:	☐ Tobacco use ☐ Psycho-social issues*, please specify:	☐ Tobacco use ☐ Psycho-social issues*, please specify:
☐ 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**

To email your request form **CLICK HERE**