



# CradleME is open to all birthing families in Maine.

Sign up for more information!

## PART 1: FAMILY INFORMATION

**YES!** I am interested in learning more about Cradle ME program that is offered to all Maine mothers and their babies. Please have a Cradle ME representative call me about the free services that are available for me and my baby. I give permission for the information I have provided below on the CradleME Request Form to be shared with individuals or organizations involved with CradleME to provide me with services related to my pregnancy, birth or having a new baby.

**Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Your Baby's Name: \_\_\_\_\_ Your Baby's Date of Birth: \_\_\_/\_\_\_/\_\_\_  Boy  Girl

For multiple births, please write babies' names here: \_\_\_\_\_

Pediatrician Name: \_\_\_\_\_ Pediatrician Phone: (\_\_\_\_) \_\_\_\_\_

### Who should be contacted about the CradleME program?

Your Name: \_\_\_\_\_ Your Date of Birth: \_\_\_/\_\_\_/\_\_\_

Relationship to Child:  Mom  Dad  Kinship Placement  Non-kinship Guardian or Foster Parent  Adoptive parent  Other: \_\_\_\_\_

Best Phone to Contact You: (\_\_\_\_) \_\_\_\_\_ 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: (\_\_\_\_) \_\_\_\_\_

## PART 2: FOR HEALTH CARE PROVIDER USE ONLY

Referent Name: \_\_\_\_\_ Referent Phone: (\_\_\_\_) \_\_\_\_\_

PRENATAL WOMAN	POSTPARTUM WOMAN	NEWBORN OR INFANT
<b>Name:</b> _____ <b>DOB:</b> _____ Reason for referral--Please check all that apply below: <input type="checkbox"/> <b>WELL-PREGNANCY AND PARENTING SUPPORT AND EDUCATION</b> <input type="checkbox"/> <b>CONCERNS FOR FOLLOW-UP BY NURSE AND/OR FAMILY VISITOR-</b> Share concern below (Substance use, medical, or psycho-social concerns please explain below)	<b>Name:</b> _____ <b>DOB:</b> _____ Reason for referral--Please check all that apply below: <input type="checkbox"/> <b>PARENTING AND INFANT CARE SUPPORT AND EDUCATION</b> <input type="checkbox"/> <b>CONCERNS FOR FOLLOW-UP BY NURSE AND/OR FAMILY VISITOR-</b> Share concern below (Substance use, medical, or psycho-social concerns please explain below)	<b>Name:</b> _____ <b>DOB:</b> _____ Reason for referral--Please check all that apply below: <input type="checkbox"/> <b>INFANT FEEDING SUPPORT AND EDUCATION:</b> <input type="radio"/> Breastfeeding <input type="radio"/> Breast & Bottle <input type="radio"/> Bottle <input type="checkbox"/> <b>CONCERNS FOR FOLLOW-UP BY NURSE AND/OR FAMILY VISITOR-</b> Share concern below

### Concerns & Comments

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Health provider: Please complete this Cradle ME request and FAX to: (207) 287-4577