

MARYLAND POSTPARTUM INFANT AND MATERNAL REFERRAL FORM

FACSIMILE (FAX) COVER SHEET

Date: _____

SENT TO:

Local Health Dept: _____

(NOTE: Some locations may require you to dial '1' before the area code.)

ATTENTION: Maternal-Child Health Program

Number of Pages Transmitted (including this page): _____

SENT BY:

Contact Name : _____

Referring Hospital: _____

Fax Number : _____

Phone Number : _____

If questions, call: _____

Comments/
Notes: _____

Print Form

CONFIDENTIALITY NOTICE

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HIPAA Under HIPAA, a health care provider may disclose protected health information (PHI) to another provider or to a covered entity, including a managed care organization or other health plan, to facilitate treatment, including the provision, coordination, or management of health care and related services by one or more health care providers, without the authorization of an individual. 45 C.F.R. § 160.103, § 164.501 and § 164.506(c)(1) and (2). In addition, HIPAA permits a health care provider to disclose PHI, without the authorization of an individual, to public health authorities -- such as local health departments and family health administration programs of the Maryland Department of Health and Mental Hygiene -- that are authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury or disability, including but not limited to the reporting of disease, injury, or vital events such as birth or death, and conducting public health surveillance. 45 C.F.R. § 164.512. Therefore, patient authorization is not required to complete and submit this form by facsimile, encrypted email, or other secure means, to the designated health care provider, health plan, or public health authority.

MATERNAL DEMOGRAPHICS

Mother's Last Name: _____ First Name: _____ Middle Name: _____

House #: _____ Street Name: _____ Apt: _____ City: _____ State: MD Zip: _____ County: _____

SSN: _____ DOB (MM/DD/YYYY): _____ Age: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

Name and Relationship of Emergency Contact: _____

EDUCATION: Highest Grade Completed: _____ Currently in School GED **PAYMENT STATUS (Mark all that apply):**

ETHNICITY: Hispanic Language Barrier Primary Language: _____ Private Insurance Specify: _____

RACE (Check all that apply): _____ MA/Health Choice MA Number: _____

African American/Black Asian Unknown/Not Reported Name of MCO (if applicable): _____

Alaska Native White Applied for MA Date: _____

American Indian Native Hawaiian/Pacific Islander Uninsured Unknown

Maternal Care Provider Name: _____ Child's MA Number: _____

Provider Address: _____ City: _____ State: MD Zip: _____ Phone: _____

PRENATAL HISTORY

Trimester of 1st Prenatal Visit: _____ Initial EDC: _____ Date of Delivery: _____ Birth Hospital: _____

OB HISTORY: _____

Full Term live births: _____ # Pre-Term live births: _____ # Prior LBW births: _____ # Spontaneous abortions: _____

Therapeutic abortions: _____ # Stillbirths: _____ # Ectopic pregnancies: _____ # Children now living: _____

HISTORY OF: _____

Pre-term labor Fetal death (>20 weeks) Infant death Multiple gestation Infertility treatment First Pregnancy

SERVICES RECEIVED THIS PREGNANCY: _____

Domestic Violence Home Visiting/Case Management Smoking Cessation STD Treatment * Substance Abuse/Mental Health * WIC

*Please Specify: _____

CHILD'S INFORMATION

Child's Last Name: _____ First Name: _____ Middle Name: _____ Gender: _____

Gestational Age (wks): _____ Birthweight (grams): _____ Apgar (1): _____ Apgar (5): _____ Multiple Birth Birth Order: 1 _____ of 1

CHILD'S RACE (Check all that apply): _____ **INFANT CARE RECEIVED:** _____

African American/Black American Indian White Unknown/Not Reported Full Term Nursery

Alaska Native Asian Native Hawaiian/Pacific Islander Special Care Nursery

Pediatric Care Provider Name: _____ Neonatal Intensive Care Unit

Provider Address: _____ City: _____ State: MD Zip: _____ Phone: _____

ASSESSMENT FACTORS

<p>MATERNAL MEDICAL RISKS:</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> BMI <18.5 or BMI >=30</p> <p><input type="checkbox"/> Chronic Hypertension</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II</p> <p><input type="checkbox"/> Physical Disability</p> <p><input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> Other Medical Condition**</p>	<p>PSYCHOSOCIAL RISKS:</p> <p><input type="checkbox"/> Alcohol use</p> <p><input type="checkbox"/> CPS case involving family**</p> <p><input type="checkbox"/> History of abuse/violence**</p> <p><input type="checkbox"/> History of depression/mental illness</p> <p><input type="checkbox"/> Illegal substance use**</p> <p><input type="checkbox"/> Inadequate shelter/homelessness</p> <p><input type="checkbox"/> Lack of social/emotional support</p> <p><input type="checkbox"/> Maternal-infant attachment/parenting deficit</p> <p><input type="checkbox"/> Smoking/Tobacco Use</p>	<p>PREGNANCY RELATED RISKS:</p> <p><input type="checkbox"/> Age < 18</p> <p><input type="checkbox"/> Age >= 40</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Gestational <input type="checkbox"/> Insulin Dependent</p> <p><input type="checkbox"/> Gestational Hypertension</p> <p><input type="checkbox"/> Pre-eclampsia/Eclampsia</p> <p><input type="checkbox"/> Sexually transmitted infection</p> <p><input type="checkbox"/> Other Pregnancy-Related Risk**</p>	<p>INFANT RISKS:</p> <p><input type="checkbox"/> Apgar <4 at 5 minutes</p> <p><input type="checkbox"/> Birth Defect/Syndrome**</p> <p><input type="checkbox"/> BW < 1500 gms</p> <p><input type="checkbox"/> Congenital Infection**</p> <p><input type="checkbox"/> Gestational Age < 34 weeks</p> <p><input type="checkbox"/> Hearing risk/diagnosis**</p> <p><input type="checkbox"/> Medical Condition**</p> <p><input type="checkbox"/> Metabolic Disorder**</p> <p><input type="checkbox"/> Neurological Condition**</p> <p><input type="checkbox"/> Positive Tox Screen**</p> <p><input type="checkbox"/> SGA</p> <p><input type="checkbox"/> Vision risk/diagnosis**</p>
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****Please Specify or Add Comments** _____

REFERRALS:

Breastfeeding support FP/reproductive health plan Immunization - infant*** Maternal medical follow-up Substance abuse

Crib/safe sleep Home Visiting/Case Management Immunization - mother*** Mental Health WIC

Domestic violence Housing Infant medical follow-up Smoking cessation Other***

***Please Specify: _____