Practice Guidelines for Providers
For all Expectant Mothers

Right Start Prenatal Guidelines and Assessment

Approved by Corporate Quality Management Committee on: 05/07/19

Originally approved by Quality Management Committee on: 11/00

Reviewed annually before every January Quality Management Committee meeting (unless otherwise noted)

Revisions: Guideline revisions sent to Quality Management Committee on: 01/11/11, 01/10/12, 01/07/14, 10/05/15, 10/04/16, 10/10/17, 10/09/18
Help Your Patients Get The Most From Right Start

About Right Start

• Complete Right Start initial assessment in the first trimester of pregnancy and fax or mail to program coordinator
• Form must be received before patient reaches 15 weeks gestation for physician to qualify for $100 reimbursement (high risk)

For more information or to fax or mail initial assessment forms, contact the program coordinator at:

Right Start
40 Century Hill Drive
Latham, NY 12110
Phone: 1-518-220-4650 or 1-800-422-7333
Fax: 1-518-220-4624 1-877-454-4624

For service and reimbursement information contact Customer Service Department at 1-518-220-4600 or 1-800-888-1238.

In-Home Care

Members who would benefit from additional educational opportunities can be referred for in-home care. This individual counseling is designed to enhance information and services provided in the physician’s office.

In-home care is free of charge to pregnant enrolled members and includes:
• Skilled nursing visits by a certified maternal/child care nurse
• One-on-one counseling and meal planning with a registered dietician including specialty diets and diet-related risk factors (i.e., obesity, hypertension, gestational diabetes, hyperemesis)
• Medical social worker counseling to address psychosocial and financial concerns.
Initial Visit and Education

Preconception care — includes identifying those conditions that could affect a future pregnancy but may be avoided by early intervention.

ACOG has grouped the main components of preconception care under four categories of intervention.

• Maternal assessment (e.g., family history, behaviors, obstetrical history, general physical exam, etc.)
• Vaccinations (e.g., Rubella, Varicella and Hepatitis B)
• Screening (e.g., HIV, STD, genetic disorders, etc.)
• Counseling (e.g., folic acid consumption, smoking and alcohol cessation, weight management, etc.)

When to schedule the initial visit:

Prior to 14th week gestation

• Members must be scheduled for an appointment within these time frames for 1st, 2nd and 3rd trimesters: Once enrollee has contact with the provider, initial prenatal visits: within 3 weeks during first trimester, within 2 weeks during the second trimester, and within 1 week during the third trimester.

What should be completed at this visit:

0-14 weeks gestation send Prenatal Program initial assessment form to the prenatal coordinator.

Comprehensive health history to include:

• Epilepsy
• Cardiovascular disease
• Hematological disorders
• MHSA (Mental Health & Substance Abuse) history
• Malignancy surgeries/hospitalizations
• Asthma
• UTI/Kidney disease
• Diabetes, other metabolic disorders
• Menstrual history
• Ethnicity, psychosocial, economic history

Family history to include:

• Congenital abnormalities
• Genetic abnormalities – screening for genetic disorders
• Cardiovascular diseases
• Multiple births
• Malignancy
• Metabolic diseases

Detailed record of current pregnancy

Estimated date of delivery

Nutritional profile — to include folic acid intake

Nutritional screen. Counseling, monitoring and f/u of all pregnant women at nutritional risk by a nutritionist or registered dietician.

OB history

• Abnormal pap
• Fertility therapy
• Prior amniocentesis
• Total number of pregnancies regardless of outcome
• Number of premature deliveries
• Number of living children
• Length of each gestation
• Complication of pregnancy, labor or delivery for each birth
• Route of delivery

• Multiple gestations
• Number of full term pregnancies
• Number of spontaneous and induced abortions
• Dates of previous pregnancies
• Birth weight for each delivery
• STD
• Previous C/S
• Prior LBW (<2,500 gm)
• Toxemia/eclampsia
• Incompetent cervix
• Uterine malformation

Physical Exam

• Height
• Weight
• BMI
• Blood pressure
• HEENT
• Thyroid

Pelvic Exam

• Adnexa
• Bony pelvis
• Rectum
• Vagina
• Vulva

Psychosocial assessment to include: screening for social, economic, psychosocial and emotional problems including referrals as appropriate to the needs of the woman and follow up.

Assessment of the parent’s attitude toward pregnancy

• Support systems available.
• Need for parenting education.
**Interval Visits**

*When to schedule the interval visits:*
- Every 4 weeks (0-28 weeks)
- Every 2-3 weeks (29-36 weeks)
- 1/week > 36 weeks

*What should be completed at all interval visits:*
- Blood pressure
- Maternal weight
- Urinalysis for sugar and albumin
- Gestational age
- Fetal heart rate and/or Fundal height
- Review and documentation re: identification of medical, obstetrical, nutritional, psychosocial, genetic and environmental factors

*What should also be completed at > 36 weeks visits:*
- Fetal presentation

**Treatment and Home Care Options**

**Home care:**
- Fetal monitoring/doppler
- Movement kick counts
- Diabetic management:
  - Diet therapy/meal planning with Registered Dietician
  - Insulin
  - Blood glucose monitoring
  - Urine ketone monitoring

Services provided by home care for follow up on all at or high risk members in the Prenatal Program.
- Skilled nursing referral
- Registered dietician referral
- Medical social worker
- Smoking cessation counseling
- Behavioral Health

The Right Start program home care option includes skilled nursing visits by certified maternal/child care RNs, in-home Registered Dietician which includes one-on-one counseling, meal planning for specialty diets and diet related risk factors, ie: obesity, hypertension, gestational diabetes, hyperemesis. In-home medical social worker to address psychosocial/financial concerns. All of the above services are copay exempt (free of charge to all pregnant members).*

* NYS Maternity Legislation 1/1/97 - early discharge entitles member to skilled nursing visit in home (within 24 hours of discharge, < 48 hours for vaginal delivery and < 96 hours for c-section). No copay for these visits.
### Risk Factors To Be Assessed

- Maternal age
- Diabetes/Gestational Diabetes
- Heart, pulmonary, hepatic, collagen & infectious disease
- Hypertension/PIH
- Neurologic disorders
- Renal disease
- Abruptio placenta
- History of conizations of cervix
- Pregnancy losses
- Placenta previa
- Preterm labor (onset of labor > 20 weeks < 37 weeks with contractions and progressive cervical changes)
- Previous congenital anomalies
- Previous preterm delivery
- DES exposure/ Teratogens
- Depressed social-economic status
- Domestic violence
- Lead
- Medications
- Nutritional Status
- Smoking
- Mental Health
- Previous C-Section
- Prior LBW (<2500 grams)
- Illicit drug use
- Nutritional Risk/BME

**Genetic Screening/Teratology Counseling**
Includes patient, baby’s father, or anyone in either family with:

- Patients age > 35 years
- Thalassemia (Italian, Greek, Mediterranean or Asian background) MCV < 80
- Neural Tube Defect (Meningomyelocele Spina Bifida or Anencephaly)
- Tay-Sachs (e.g. Jewish, Cajun, French Canadian)
- Mental Retardation/ Autism — if yes, was person tested for Fragile X
- Medications (Including, supplements, vitamins, herbs, or OTC drugs)/ Illicit/Recreational Drugs/Alcohol since last menstrual period
- Congenital Heart Defect
- Down Syndrome
- Sickle Cell Disease or Trait (African)
- Hemophilia or other blood disorders
- Canavan disease
- Cystic Fibrosis
- Huntington Chorea
- Other inherited genetic or chromosomal disorders
- Maternal metabolic disorders (e.g. Insulin-Dependent Diabetes, PKU)
- Recurrent pregnancy loss, or a stillbirth
- Patient or baby’s father had a child with birth defects not listed above
- Muscular Dystrophy

Contact Case Manager with Right Start members initial assessment form to enroll in Right Start Case Management.
1-518-220-4650 1-518-220-4624 (fax) 1-800-422-7333
**Prenatal Education**

- Signs of pregnancy complications
- Toxoplasmosis precautions (cats/raw meat)
- Sexual activity
- Nutrition counseling
- Environmental/work hazards
- Genetic testing
- HIV counseling and education (NYS information line 1-800-541-AIDS)
  - All patients to be tested for HIV antibodies must be provided with pre-and post-test counseling in compliance with New York State HIV Confidentiality Law (Public Health Law Article 27-F). **Medical record documentation is required.**
- Depression
- Domestic violence
- VBAC counseling
- Lifestyle modifications:
  - Alcohol
  - Substance abuse
  - Tobacco counseling - refer for smoking cessation counseling
- Childbirth class (free through our Health Education classes)
- Labor signs/preterm labor signs
- Anesthesia plans
- The consequences of ingesting solid food after the onset of labor, given that a general anesthetic could be required for the delivery

**Prebooking/Transfer of Information to Delivery Sites**

- A system for sharing medical records with the delivery site and receiving information from referral sources and delivery sites.
- Pre-booking women for delivery at 34-36 weeks gestation for low risk pregnancies.
- Pre-booking women for delivery at 26 weeks gestation for high risk pregnancies.
**Laboratory Diagnostics**

**Initial Labs**
- Blood type
- D(Rh) type
- Antibody screen
- HCT/HGB
- Pap test/Cervical Cytology
- Rubella/Varicella
- Vaginal Culture
- RPR/VDRL
- Urine culture/screen
- HbsAg
- Chlamydia
- GC screening
- HIV counseling/testing
- TSH

**Additional Labs (if indicated)**
- HgB Electrophoresis
- PPD
- Lead Screening
- Sickle Cell
- Tay-Sachs
- Genetic Screening
- Gonorrhea
- TSH
- GTT

**8 - 18 Week Labs (when indicated/elected)**
- Ultrasound
- MSAFP/Multiple Markers, consent or refusal signed or documented
- Amnio/CVS:
- Karyotype
- Amniotic Fluid (AFP)

**24 - 28 Week Labs**
- HCT/HGB
- D(Rh) Antibody screen
- Diabetes screen
- GTT (if screen abnormal) (RhIG) given (28 weeks)(*)
  *Administer Rho(D) immune globulin prophylactically by 28 weeks if repeat antibody screen indicates unsensitized RH.

**32 - 36 Week Labs (when indicated)**
- HCT/HGB (recommended)
- Chlamydia
- VDRL
- Repeat HIV testing
- Group B Strep (35-37 weeks) GC

**Postpartum Visit and Education**

**When to schedule the postpartum visit:**
- 7 - 14 days after cesarean delivery and/or complicated gestation
- 21 - 56 days for all deliveries

**What should be completed at this visit:**
- Documentation re: delivery outcome and health status of mother/infant including Medical/psychosocial needs with appropriate referrals if indicated.
- Complete physical exam:
  - assessment of the breasts
  - blood pressure
  - abdomen, external and internal genitalia
  - weight
- Laboratory studies - as indicated by the assessment
- Psychosocial: assess for postpartum depression and link patient with appropriate services:
- Nutrition/breast feeding counseling
- Family planning:
  - sexual activity
  - preconception
  - contraception
  - sterilization counseling
- Assess family planning needs and provide advice and services on referral where indicated
- Tobacco counseling

Source:
Right Start Prenatal Program
Smoking Cessation

It’s a fact that 21-22%* of low birth weight babies are born to mothers who smoke. Identify smokers on the initial assessment form and they will be referred for smoking cessation counseling.

Implement the 5 A's

Physicians could improve the 20% low birth weight statistic by implementing the Agency for Healthcare Research and Quality (AHCPR) tobacco cessation “4 A’s” interventions in their office practice.

Ask

Identify and document tobacco use status on all pregnant women at every visit.

Advise

Deliver a clear, strong and personalized message to every pregnant tobacco user to quit. Example: “Quitting smoking is the best action you can take for your health and your baby’s health. As your doctor, I strongly encourage you to quit.”

Assess

Determine client’s willingness to quit.

Assist

Help the pregnant tobacco user with a quit plan and educational materials.

Arrange

Refer the pregnant tobacco user to call 1-518-220-5800 or 1-800-459-7587 for educational and referral information.
# WNY COLLABORATIVE
## PRENATAL CARE RISK SCREENING and REFERRAL FORM

### Member Information

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<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<td>Last Name</td>
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<tr>
<td>First Name</td>
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<td>ID #</td>
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<tr>
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<td>Zip</td>
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<tr>
<td>Home Phone</td>
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<td>Work/Cell phone</td>
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<td>DOB</td>
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### PNC Provider Information

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<td>Phone</td>
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<td>Provider FAX</td>
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### Pregnancy Information

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<td>Initial Visit Date</td>
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<td>Gestational Age at time of PNV (weeks)</td>
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<tr>
<td>Gravida</td>
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<td>Para</td>
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<tr>
<td>LMP</td>
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<td>EDC</td>
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<td>Height</td>
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<tr>
<td>Weight</td>
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<td>Pre-pregnancy BMI</td>
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### Demographic Information: Choose ALL that apply

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<th>Category</th>
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<td>Race/ethnicity</td>
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<td>Black or African American</td>
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<tr>
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<tr>
<td>Primary Language</td>
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<td>English</td>
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<td>Spanish</td>
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<td>Other (specify)</td>
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<td>Hispanic</td>
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### Pregnancy Risk Factors: Choose ALL risk factors that apply

<table>
<thead>
<tr>
<th>Factor</th>
<th>Prior</th>
<th>Current</th>
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<tbody>
<tr>
<td>Abdominal surgery</td>
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<tr>
<td>C-Section</td>
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<td>Cervical incompetence</td>
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<tr>
<td>Placenta Abruptio</td>
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<tr>
<td>Placenta Previa</td>
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<tr>
<td>Pre-term labor</td>
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<tr>
<td>Preterm birth &lt;37 wks</td>
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<tr>
<td>LBW &lt;2500gms 5 1/2 lbs</td>
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<tr>
<td>Pt wt &gt;4500gms/10lbs</td>
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<tr>
<td>Stillborn/fetal death &gt;22 wks</td>
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<tr>
<td>Fetal abnormality</td>
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<td>Multiple gestation</td>
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<tr>
<td>HTN/Preeclampsia</td>
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<tr>
<td>Gestational Diabetes</td>
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<tr>
<td>STDs</td>
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<td>&lt;16 yr or &gt; 35</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Alcohol use</td>
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<td>Tobacco use</td>
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<tr>
<td>Drug use</td>
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<tr>
<td>Medically Assisted Therapy</td>
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### Medical Risk Factors: Choose ALL risk factors that apply

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<tr>
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<th>On Meds</th>
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<tr>
<td>Anemia</td>
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<tr>
<td>Diabetes Mellitus</td>
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<td>Asthma</td>
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<td>DVT/Pulmonary Embolism</td>
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<td></td>
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<tr>
<td>Auto-Immune disorder</td>
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<td>Cardiac history</td>
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<td>Hypertension</td>
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<td>Kidney disease</td>
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<td>Thyroid disorder</td>
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<td>Seizures</td>
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<td>HIV/AIDS</td>
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<td>Unplanned pregnancy</td>
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<tr>
<td>Eating disorder</td>
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<td>Underweight</td>
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<td>Overweight/Obese</td>
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<tr>
<td>Lead Exposure</td>
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### Referrals Made: Check actions taken by the provider and/or those refused by the patient

<table>
<thead>
<tr>
<th>Factor</th>
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<th>Refused</th>
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<tbody>
<tr>
<td>Community Case Manager</td>
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<tr>
<td>Health Plan Case Manager</td>
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<td>Behavioral / mental health</td>
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<td>Domestic violence</td>
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<tr>
<td>High risk OB</td>
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<tr>
<td>Substance abuse</td>
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<td>Tobacco cessation program</td>
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<td>Asthma educator</td>
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<tr>
<td>Diabetes educator</td>
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<tr>
<td>Home Visit Provider</td>
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<tr>
<td>Nutritional Assistance Program</td>
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<td>WIC</td>
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<tr>
<td>Nutrition Counseling</td>
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<tr>
<td>Other</td>
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</table>

1) Do you or your patient want assistance with linkage or referral services? [ ] YES  [ ] NO
2) Do you want to refer your patient (if applicable) to Nurse Family Partnership? [ ] YES  [ ] NO

Name: ___________________________ Date: _______________ Practitioner Signature or office stamp: ___________________________
Nurse Family Partnership is available to first-time moms who are pregnant (28 weeks or less), WIC eligible and live in a participating service area (currently offered in Chautauqua, Erie, Monroe & Niagara counties). The program provides free help from a personal nurse who will conduct home visits to offer advice, education and support throughout the pregnancy and until the baby is 2 years old. For more information, please visit: https://www.nursefamilypartnership.org/first-time-moms/.
NEW YORK STATE DEPARTMENT OF HEALTH
BEST PRACTICES FOR BREASTFEEDING

Breastfeeding Promotion Guidelines for Ambulatory Care Settings
(Physician Offices, Health Centers, WIC)

1. Visible support for breastfeeding, e.g. culturally appropriate pictures or posters that shows women breastfeeding in positive and realistic settings.

2. Positive staff attitudes toward breastfeeding at all levels of the organization (from Housekeeping to the Medical Director and Chief Executive Officer)

3. Comfortable chairs in waiting room for mothers to sit in while breastfeeding.

4. Private space available for breastfeeding, when desired by mothers.

5. Lactation specialist on staff, preferably IBCLC.

6. Breastfeeding home visit and/or telephone contact with all breastfeeding mothers, provided by staff or peer counselor soon after discharge from hospital.

7. Knowledgeable support for breastfeeding after returning to work.

8. Breastfeeding classes on-site.

9. Appropriate resource materials – pamphlets, books, videos from Best Start, NYSDOH, and other reliable sources.

10. No formula company materials – pamphlets, videos, pens, mugs, other “gifts”.

11. Breastfeeding "warm line” for families to call for advice about breastfeeding.

12. Information provided to mothers about community resources, e.g. peer counselors, sources of pump rentals and other breastfeeding supplies.

13. Breastfeeding assessed at each pediatric and postpartum visit.

14. Medication choices for mother consider her breastfeeding status, e.g. recommend contraceptives other than estrogen/progestin methods.

15. Duration of breastfeeding monitored.

NYSDOH – Updated June 2004
Consent for Release of Information

Patient Name: _________________________ __________________ ____________

Date of Birth: _____________ Managed Care Plan: ______________________________

Enrolled in Medicaid: □ YES □ NO County: ____________________________________

CIN #: __________________________

Check all that apply:

☐ I authorize my health care provider (name of health care provider) to release my confidential information listed on the New York State Prenatal Care Risk Form and any information provided during my evaluation by my health care provider to (name of coordinator) for the purposes of coordination of care, payment of claims for services, quality improvement of services, screening for program eligibility, and care and treatment.

☐ I authorize release of my confidential information listed on the New York State Prenatal Care Risk Form by (name of coordinator) to any or all of the following providers or organizations that may be providing care or services to me, as applicable: my managed care plan, my health care providers, my county health department, agencies or organizations providing prenatal services or other social or family health services including but not limited to those listed on Attachment A of this consent form.

☐ I understand that my confidential information may include HIV/AIDS, mental health, adult/child abuse or alcohol/substance abuse information about me. I hereby give my consent to the release of such information to the (name of coordinator) and entities or organizations listed above that will be providing care or services to me.

I understand that any disclosure of the records of Federally assisted alcohol or drug abuse treatment programs is bound by Title 42 of the Code of Federal Regulations.

I understand that this consent for release of information is voluntary, and that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for a managed care plan’s eligibility or enrollment determinations relating to me.

I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

I understand that the recipient of my confidential information may not be required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and therefore the recipient of my confidential information may re-disclose it.

I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I can withdraw my consent by notifying (name of coordinator) in writing at the following address:

_____________________________________________________________________________________

If not previously revoked, this consent shall expire one year from its signing.

Patient’s Signature Date Witness Signature Date

Print Patient’s Name Signature of Personal Representative of Patient
Dear Provider:

If any high-risk factors are identified on this prenatal member, she is eligible to have prenatal and postpartum Home Health Care visits for education and skilled needs.

*Please include this referral form along with the initial referral form Only if referring for homecare services.*

Date of Referral: 

Patient Name: 

Patient ID Number: 

*Please let us know if you recommend a homecare referral by checking below and faxing to the appropriate managed care organization.*

- [ ] Skilled Nursing
- [ ] Registered Dietician
- [ ] Educational Visit
- [ ] Social Worker
- [ ] Behavioral Health

Reason: 

Physician Signature: ___________________________ Date: ___________________________