Prenatal Referral Form (PRF) **Please fax including a cover sheet to Quality: 1(877) 244-3771**

Member Information

Last Name: ______________________________ First Name: ___________________________ ID #:____________________

Street Address: _________________________________ City _________________ State: ________ Zip: _______________

Home Phone: _______/_______/__________ Work/Cell phone: ______/______/________ DOB: ____/____/_______ (MM DD YYYY)

Provider Information

Last Name: _________________________________ First Name: ______________________ Group Name: _____________

Address: _________________________________ City: ______________________ State:_________ Zip: _______________

Provider ID#: ___________ Tax ID#: ______________ Phone: ______/______/_____ Provider FAX:_____/______/______

Pregnancy Information

Initial Visit Date:____/____/______ (MM DD YYYY) Gestational Age at time of PNV (weeks): ______ ☐ by LMP **OR** ☐ by Ultra sound

Gravida: ________ Para: __________ LMP ____/___/________ (MM DD YYYY) EDC ____/___/________ (MM DD YYYY)

Height:_______________ Weight:________________ Pre-pregnancy BMI: _____________

Demographic Information: Choose ALL that apply

Race/ethnicity: ☐ Caucasian ☐ Black or African American ☐ Asian ☐ American Indian ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Other (specify) ____________________ Hispanic: ____ Yes / ____ No

Pregnancy Risk Factors: Choose ALL risk factors that apply

Prior	Current		Prior	Current		Prior	Current		Prior	Current	
☐	☐	Abdominal surgery	☐	☐	Pre-term labor	☐	☐	Fetal abnormality	☐	☐	<16 yr or > 35
☐	☐	C-Section	☐	☐	Preterm birth <37 wks	☐	☐	Multiple gestation	☐	☐	Depression
☐	☐	Cervical incompetence	☐	☐	LBW <2500gms 5 ½ lbs	☐	☐	HTN/Preeclampsia	☐	☐	Alcohol use
☐	☐	Placenta Abruptio	☐	☐	Bt wt >4500gms/10lbs	☐	☐	Gestational Diabetes	☐	☐	Tobacco use
☐	☐	Placenta Previa	☐	☐	Stillborn/fetal death >22 wks	☐	☐	STDs ____________	☐	☐	Drug use

Medically Assisted Therapy: ___________

Medical Risk Factors: Choose ALL risk factors that apply

Yes	On Meds		Yes	On Meds		Yes	On Meds		Yes	On Meds	
☐	☐	Anemia	☐	☐	Diabetes Mellitus	☐	☐	Hypertension	☐	☐	Eating disorder
☐	☐	Asthma	☐	☐	DVT/Pulmonary Embolism	☐	☐	Kidney disease	☐	☐	Underweight
☐	☐	Auto-Immune disorder	☐	☐	Dental problem	☐	☐	Thyroid disorder	☐	☐	Overweight/Obese
☐	☐	Cardiac history	☐	☐	HIV/AIDS	☐	☐	Seizures	☐		Lead Exposure

Psycho-Social Risk Factors: Choose ALL risk factors that

☐ Unmarried/NO partner	☐ Unemployed (patient)	☐ Physical disability	☐ Unplanned pregnancy	Yes / On Meds
☐ No family support	☐ Husband/partner unemployed	☐ Sexual abuse	☐ Children in foster care	☐ ☐ Psychiatric diagnosis
☐ Unstable housing	☐ Education <12 yrs	☐ Physical abuse	☐ Language barrier	
☐ Homeless	☐ Transportation problem	☐ Risk of self-harm		
☐ Health Home	☐ Mental disability	☐ Domestic violence		

Referrals Made: Check actions taken by the provider and/or those refused by the patient

Yes	Refused		Yes	Refused		Yes	Refused		Yes	Refused	
☐	☐	Community Case Manager	☐	☐	High risk OB	☐	☐	Asthma educator	☐	☐	WIC
☐	☐	Health Plan Case Manager	☐	☐	Substance abuse	☐	☐	Diabetes educator	☐	☐	Nutrition Counseling
☐	☐	Behavioral / mental health	☐	☐	Tobacco cessation program	☐	☐	Home Visit Provider	☐	☐	Other
☐	☐	Domestic violence	☐	☐	Dental care	☐	☐	Supplemental Nutrition Assistance Program (Food Stamps)			

1) Do you or your patient want assistance with linkage or referral services? ☐ YES_________________________________

Name: _______________________________ Date: ______________ Practitioner Signature or office stamp:

Provider completing form

Current Pregnancy Risk: ☐ High ☐ At-Risk ☐ Low