

MARYLAND POSTPARTUM INFANT AND MATERNAL REFERRAL FORM

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: _____ 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):**
 Private Insurance Specify: _____
 MA/Health Choice MA Number: _____
 Name of MCO (if applicable): _____
 Applied for MA Date: _____
 Uninsured Unknown
 Child's MA Number: _____

ETHNICITY: Hispanic Language Barrier Primary Language: _____
RACE (Check all that apply):
 African American/Black Asian Unknown/Not Reported
 Alaska Native White
 American Indian Native Hawaiian/Pacific Islander

Maternal Care Provider Name: _____ Child's MA Number: _____
 Provider Address: _____ City: _____ State: _____ 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:
 IPV Home Visiting/Case Management Smoking Cessation STD Treatment * Substance Use/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: _____ of _____
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
 Neonatal Intensive Care Unit
 Pediatric Care Provider Name: _____
 Provider Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

ASSESSMENT FACTORS

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

REFERRALS:
 Breastfeeding support FP/reproductive health plan Immunization - infant*** Maternal medical follow-up Substance Use
 Crib/safe sleep Home Visiting/Case Management Immunization - mother*** Mental Health WIC
 IPV Housing Infant medical follow-up Smoking cessation Other***

***Please Specify: _____

FORM COMPLETED BY : _____ AGENCY/HOSPITAL : _____ DATE: _____

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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

SENT BY:

Contact Name :

Referring Hospital:

Fax Number :

Phone Number :

If questions, call:

Comments/ Notes:

CONFIDENTIALITY NOTICE

This facsimile transmission may contain confidential information belonging to the sender. The information is intended solely for the use of the individual(s) or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, and/or distribution of this information is strictly prohibited. If you have received this transmission in error, please immediately notify the sender by phone to arrange for the return of the documents.