

# 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

**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

<b>MATERNAL MEDICAL RISKS:</b> <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**	<b>PSYCHOSOCIAL RISKS:</b> <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	<b>PREGNANCY RELATED RISKS:</b> <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**	<b>INFANT RISKS:</b> <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**
---	---	--	---

**\*\*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: \_\_\_\_\_

# 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**

**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.