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: 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

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: _____

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

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: _____

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: 1 of 1

CHILD'S RACE (Check all that apply): _____

☐ African American/Black ☐ American Indian ☐ White ☐ Unknown/Not Reported
☐ Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander

Pediatric Care Provider Name: _____

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

INFANT CARE RECEIVED:

☐ Full Term Nursery
☐ Special Care Nursery
☐ Neonatal Intensive Care Unit

ASSESSMENT FACTORS

MATERNAL MEDICAL RISKS:

☐ Anemia
☐ Asthma
☐ BMI <18.5 or BMI >=30
☐ Chronic Hypertension
☐ Diabetes ☐ Type I ☐ Type II
☐ Physical Disability
☐ Sickle Cell Disease
☐ Other Medical Condition**

PSYCHOSOCIAL RISKS:

☐ Alcohol use
☐ CPS case involving family**
☐ History of abuse/violence**
☐ History of depression/mental illness
☐ Illegal substance use**
☐ Inadequate shelter/homelessness
☐ Lack of social/emotional support
☐ Maternal-infant attachment/parenting deficit
☐ Smoking/Tobacco Use

PREGNANCY RELATED RISKS:

☐ Age < 18
☐ Age >= 40
☐ Diabetes ☐ Gestational ☐ Insulin Dependent
☐ Gestational Hypertension
☐ Pre-eclampsia/Eclampsia
☐ Sexually transmitted infection
☐ Other Pregnancy-Related Risk**

INFANT RISKS:

☐ Apgar <4 at 5 minutes
☐ Birth Defect/Syndrome**
☐ BW < 1500 gms
☐ Congenital Infection**
☐ Gestational Age < 34 weeks
☐ Hearing risk/diagnosis**
☐ Medical Condition**
☐ Metabolic Disorder**
☐ Neurological Condition**
☐ Positive Tox Screen**
☐ SGA
☐ 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: _____

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FACSIMILE (FAX) COVER SHEET

Date:

SENT TO:

Local Health Dept: Worcester County Health Department FAX 410-632-0906

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

ATTENTION: Maternal-Child Health Program

SENT BY:

Contact Name :

Referring Hospital: Western Maryland Regional Medical Center

Fax Number :

Phone Number :

If questions, call:

Comments/ Notes: