DIRECT REFERRAL FORM

TO BE FILLED OUT BY HOSPITAL STAFF ONLY

Participant Demographic Information

Name of Participant

Date of Referral

Estimated Due Date

Date of Birth

Phone Number

Email Address

Participant Address

Hospital Staff Contact Information

Name of Staff Member Referring:

Email Address

Phone Number

Participant's Medical Information

Obstetrical H=history C=current		Medical		Psychosocial	
☐ Preterm labor / delivery	H / C	Diabetes Mellitus	☐	Tobacco / Alcohol use	☐
☐ Multiple Gestation	H / C	Anemia	☐	Tobacco Cessation (Prescription or Referral given)	☐
☐ Gestational diabetes	H / C	Hypertension	☐	Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc.	☐
☐ Preg Induced Hypertension	H / C	HIV+ / AIDS	☐	Current Medication Assisted Treatment	☐
☐ Cervical or Placental Abnormalities	H / C	Asthma / Respiratory condition	☐	Last delivery within 1 year of EDD	☐
☐ Prior C Section Delivery		Cardiac condition	☐	Domestic Violence	☐
☐ Inadequate weight gain / fetal IUGR		Sickle cell / clotting disorders	☐	Homeless / Unstable housing	☐
17- P Candidate ☐ Yes ☐ No		Hepatitis	☐	Anxiety / Depression / Mental Health disorder	☐
Prior NAS Delivery ☐ Yes ☐ No		STD (specify)	☐	Other Obstetrical/Medical/Social Determinant Concerns:	
		Periodontal disease	☐		