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

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

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: ______

Maternal Care Provider Name: ______

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):

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

INFANT CARE RECEIVED:

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

Pediatric Care Provider Name: ______

Provider Address: ______ City: ______ State: ______ Zip: ______ Phone: ______

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: ______

Maryland Department of Health, Office of Quality Improvement (March 2018)
This form can be found at https://phpa.health.maryland.gov/mch/Documents/MD-Infant-Postpartum-Referral-Form.pdf

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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

Number of Pages Transmitted (including this page): ________

SENT BY:

Contact Name : ____

Referring Hospital: ____

Fax Number : ________________________________

Phone Number : ________________________________

If questions, call: ____

Comments/
Notes: ____

CONFIDENTIALITY NOTICE

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Maryland Department of Health, Office of Quality Improvement (March 2018)
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