Phone: (716) 887-8734
FAX: (716) 887-7913

Phone: (716) 635-3523
FAX: (716) 631-3966

Phone: (800) 509-5290
FAX: (716) 614-5760

WNY Collaborative Prenatal Referral Form

Please complete this form and submit to the member's primary health insurance carrier prenatal program as soon as you have seen the member for her first prenatal visit.

Member Information	**Name**	**ID#**	
	Address		
	Date of Birth	**Home Phone Number**	**Work Phone Number**
	Language Indicator ☐ **English** ☐ **Spanish** ☐ **Other** ____________		
Emergency Contact	**Name**	**Relationship**	**Phone Number**
OB/Provider Information	**Name**	**Provider ID#**	**Tax ID#**
	Address		**Phone Number**
	Are you a PCAP? ☐ **Yes*** ☐ **No** **Please also refer to Prenatal Standards – 10 NYCRR Part 85.40 Regulations*		
	Form Completed By	**Contact Number**	

Member History		
EDC: ____/_____ /_____	**Date of First OB Visit:** _____/______/_____	**Height & Weight:** ______________
G: ______ **P:** __________________	**Abortions:** ____ **Miscarriages:** ________________	
Previous High Risk Pregnancy?	☐ **Yes** ☐ **No**	
Current Pregnancy Risk?	☐ **High** ☐ **At-Risk** ☐ **Low**	
Multi-Fetal Pregnancy?	☐ **Yes** ☐ **No**	
Confidential Pregnancy?	☐ **Yes** ☐ **No**	
HIV Pre-Test Counseling?	☐ **Yes** ☐ **No**	**Signature:** ☐ **Yes** ☐ **No**
Is Patient a Smoker?	☐ **Yes** ☐ **No**	**Years:** _______**Amount:** ________
Nutritional Assessment Completed?	☐ **Yes** ☐ **No**	
Referring to Home Care?:	☐ **Yes** ☐ **No** (If Yes, please complete the attached Homecare Referral Form)	

NOTE: For *all high risk* and *all Managed Medicaid Members*, the current prenatal medical record, including the complete assessment, *must be attached*.

Phone: (716) 887-8734
FAX: (716) 887-7913

Phone: (716) 635-3523
FAX: (716) 631-3966

Phone: (800) 509-5290
FAX: (716) 614-5760

Home Health Care Referral

Dear Provider:

If **any high risk factors** are identified on this prenatal member, she is eligible to have prenatal and postpartum Home Health Care visits for education and skilled needs.

Please include this referral form along with the initial referral form ONLY if referring for homecare services.

Date of Referral: ______________________________

Patient Name: ______________________________

Patient ID Number: ______________________________

Please let us know if you recommend a homecare referral by checking below and faxing to the appropriate managed care organization.

- ☐ Skilled Nursing
- ☐ Registered Dietician
- ☐ Educational Visit
- ☐ Social Worker
- ☐ Behavioral Health

Reason:

____

____

Physician Signature: ______________________________ **Date:** ____________________