Instructions: Please complete this form and fax back to Neighborhood at FAX: (401) 709-7035.
Please update the form and resend with any new information or risks associated with this pregnancy.
The following information is required by EOHHS and necessary to obtain a reference number:

OB-GYN Name: _____ 1st date of service: _____

OB site: _____ Fax: _____

Member ID: _____ Name: _____DOB: _____

Member address: _____ Phone: _____

_____

LMP (if known)_____ EDD (if known): _____ Gravida: _____ Para: _____ AB:_____ Living: _____

Consent Signatures confirm the Provider has discussed the referral with the patient and the patient has consented to telephonic contact by a case manager from our Behavioral Health partner. Referrals can also be made at any time with or by the patient by calling the Behavioral Health partner directly at (401) 459-6681. Consent Signatures for a Behavioral Health referral is required.

REFERRAL FOR BEHAVIORAL HEALTH CASE MANAGEMENT

☐ No ☐ Yes (referral reason): _____Consent Date: _____

Patient Signature: _____Provider Signature: _____

Date Prenatal Risk Assessment completed by Provider: _____

BEHAVIORAL HEALTH PRA - PLEASE CHECK ALL RISKS THAT APPLY*

☐Anxiety	☐Sexual abuse	☐ Anorexia
☐Bipolar disorder	☐Substance abuse	☐ History of PTSD
☐Depression	☐ Suicidal attempts	☐ Other BH issues: _____
☐History of Postpartum depression	☐Psychosis	☐ No risk

*** Risks checked off or written on this form do not ensure enrollment into the Bright Start Case Management Program. Neighborhood assumes the provider is managing all risks identified on this form.**

MEDICAL PRA - PLEASE CHECK ALL RISKS THAT APPLY

History of Pre-term delivery (less than 36 weeks GA) and receiving weekly injections (17P): ☐Yes ☐No

Adherence to Injection ☐Yes ☐ No

☐ Current Diabetes Mellitus

(If above is checked (active at High Risk Clinic) ☐ Yes ☐No

☐Pre-existing or chronic HTN/ on medication ☐Yes ☐ No

☐ Short-term pregnancy interval (< 12 months)

☐Smoking

☐No risks

2ND/3RD TRIMESTER RISKS

☐ Health care non-adherence: ☐ (Not following treatment plan) ☐ (Not keeping appointments)

☐ Current preeclampsia/eclampsia

☐ Gestational diabetes (If yes) Active in High Risk Clinic ☐ Yes ☐No

NEIGHBORHOOD REFERRAL FOR MEDICAL CASE MANAGEMENT

☐ No ☐Yes, referral reason: _____

☐ Have you discussed the referral with your patient? Yes_____ No_____ _____