# Maternity Care Management Program Referral Form



Please complete all of the sections below and fax the form to the Blue Shield of California Promise Health Plan Maternity Program at (844) 893-1211. Our Maternity Care team will outreach to the member within two business days of receiving your referral.

If you have questions about the Maternity Care Management Program or want to follow up on a patient, please call (888) 802-4410 (TTY: 711).

Member's name:	Member's plan ID:	Member's date of birth (DOB):
Member's street address:	City:	ZIP code:
Member's phone number:	Alternate phone number:	Member's preferred language:
Date of last pregnancy test:	Date of member's last period:	Member's ethnicity:

### Section 1: Known high-risk condition(s): Please check all that apply.

Hypertension	Mental, behavioral health condition, e.g., depression

Excessive nausea and vomiting Multiple gestation

Diabetes pre-term labor No problems with current pregnancy

Substance use, e.g., smoking, alcohol, recreational drugs, misuse of prescription

drugs

### Other (please explain):

#### Section 2: Recommendation for doula services

Doula services include health education, advocacy, and physical, emotional, and nonmedical support. Services are provided before, during, and after childbirth or at the end of a pregnancy, including the postpartum period.

Initial recommendation for doula services

- 1 initial visit; 8 prenatal or postpartum visits; Support during labor/delivery (including stillbirth or miscarriage) or an abortion; 2 three-hour-long postpartum visits

Recommendation for additional doula services (Cannot be established by standing order.)

- 9 additional prenatal or postpartum visits

Recommending provider's name:	Phone number:
Recommending provider's specialty:	Date of recommendation:

## Section 3: OB/GYN care provider

Recommending provider's name:	Phone number:	Date of member's first prenatal appointment:
Recommending provider's specialty:	Date of recommendation:	