Mississippi State Department of Health
Healthy Moms/Healthy Babies of MS
(HM/HB)

Referral
(Maternity or Infant)

FOR USE BY NON-MEDICAL SETTINGS/PERSONNEL ONLY

Referral Source

Referring agency: _____ Date: _____

Individual completing referral: _____ Title: _____

Mailing address:_____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email:_____

Client Information – (Circle one MATERNITY or INFANT)

Client Full Name	DOB	Age	Medicaid #, If Applicable
Caregiver's Name/Relationship (for INFANT/MINOR)	Home #		Cell #
Physical Address	County	City	State Zip

Pregnancy Information (for MATERNITY referral only)

Expected Due Date	Date of First Prenatal Doctor's Visit	Maternity Care Provider (Name, Contact Information)

Birth/Medical Information (for INFANT referral only)

Birth Weight lbs. oz.	Was baby born before expected due date? Yes No If yes, by how many weeks?	Infant's Doctor (Name, Contact Information)

		Reason for Referral (for MATERNITY referral only)
Yes	No	Indicate "YES" or "NO" for any of the following per the infant caregiver's report:
		Client is 17-19 years old.
		Client is 16 years old or younger.
		Client has experienced pregnancy loss or pregnancy termination in the past.
		Client has had a baby born more than 3 weeks early.
		Client's due date is less than 14 months since her last pregnancy ended.
		Client started prenatal care after several months of being pregnant.
		Client has an illness that requires ongoing medical care.
		Client has had problems with current pregnancy.
		Client has been told this baby may have birth defects or other problems.
		Client takes medication to keep her from going into labor.
		Client has been placed on bed rest at some point this pregnancy.
		Client's pregnancy is managed by a specialist.

Client Full Name: _____ DOB: _____

		Reason for Referral (for INFANT referral only)
Yes	No	Indicate "YES" or "NO" for any of the following per the infant caregiver's report:
		Mother of infant is 17-19 years old.
		Mother of infant is 16 years old or younger.
		Mother had limited prenatal care before delivery.
		Infant stayed in the intensive care/critical care nursery after birth.
		Infant was born with birth defect(s) or other problems.
		Infant has a diagnosed medical condition requiring ongoing medical management.
		Infant was born more than 3 weeks early.
		Infant sees a specialist to manage a medical condition.
		Infant sees a developmental specialist or clinic to monitor growth and development.

Other Information

This form should be submitted to MSDH Healthy Moms/Healthy Babies Central office:
Phone: 601-576-7113 Fax: 601-576-7825 Email: HM.HB@msdh.ms.gov

MSDH HM/HB Staff use Only

Healthy Moms/Healthy Babies of MS (HM/HB)
Referral Form 74 Instructions

Purpose
The purpose of the Healthy Moms/Healthy Babies of MS (HM/HB) Referral Form is to allow non-medical settings to participate in identifying pregnant women and infants up to one year old, who may be eligible for the Mississippi Department of Health HM/HB care management program and who may not otherwise be identified or referred through a medical setting.

Instructions

1. The form should be completed for pregnant women/infants up to 12 months old, who may benefit from a risk screening to determine eligibility or rule-out qualifying risks for the HM/HB care management program.
2. This form is to be used by personnel in non-medical settings, such as schools, colleges, social service agencies, youth-serving organizations, child care centers, faith-based programs/communities, justice system/detention centers, child welfare settings, and mental health settings or non-medical staff within MSDH.
3. **MSDH medical personnel and healthcare providers** are directed to **continue** using the Division of Medicaid approved Maternity and Infant Risk Screens, revised 09/30/2015. Refer to the instructions specific to this form available on the MSDH website at: http://msdh.ms.gov/msdhsite/_static/41,0,106.html
4. Referrals should be made/sent directly to the Healthy Moms/Healthy Babies Central office: Phone: 601-576-7950, Fax: 601-576-7825 Attention **HM/HB Referral**.

Please print or type the requested information in each blank (* indicates required information)

REFERRAL SOURCE
Referring agency*: Enter the name of the agency, program, or setting initiating the referral on the client's behalf
Date*: Enter the date the agency initiates the referral to MSDH HM/HB Program
Individual completing form*: Enter the name of the individual from the agency completing the referral
Title*: Enter the title or position the individual completing the form has at the referring agency
Mailing address*: Enter the mailing address for the referring agency
City*: Enter the city where the referring agency is located
State*: Enter the state the where the referring agency is located
Phone*: Enter a telephone number for the individual completing the form at the referring agency
Fax*: Enter a fax number for the individual completing the form at the referring agency
Email*: Enter an email address for the individual completing the form at the referring agency

CLIENT INFORMATION – "Client" is indicative of the pregnant woman or infant being referred.
Full Name*: Enter the client's first, middle (if known), and last name
DOB*: Enter the client's date of birth (mm/dd/yyyy)
Age*: Enter the client age in completed years
Medicaid #*: Enter the client's nine digit Medicaid number
Caregiver's Name/Relationship (for INFANT/MINOR)*: Enter name of primary caregiver for any infant client who is referred by. The agency may also enter caregiver information for minor clients here as well, though it is not required by MSDH.
Home #*: Enter the home phone number for the client
Cell #*: Enter the cell phone number for the client
Physical Address*: Enter the client's physical address (no Post Office Box addresses)
County*: Enter the county that the client resides in
City*: Enter the city that the client resides in

State: Auto-Fill with MS (Mississippi)
Zip*: Enter the zip code for the client's address that was provided

PREGNANCY INFORMATION (for MATERNITY referral only)
Expected Due Date*: Enter the expected due or delivery date based on the client's self-report
Date of First Prenatal Doctor's Visit*: Enter the date of the first prenatal care appointment based on client's self-report; if no prenatal care appointment has been initiated, enter "0"
Maternity Care Provider*: Enter the name of provider/clinic the client sees for maternity/prenatal care. Enter contact information (address, phone number) if available.

BIRTH/MEDICAL INFORMATION (for INFANT referral only)
Birth Weight*: Enter infant's birth weight using numbers for pounds (lbs) and ounces (oz).
Was baby born before due date?* YES NO: Circle YES if infant was born before expected due date. Circle NO if infant was born close, on, or after expected due date.
If yes, by how many weeks? __*: Write in the blank area the number of weeks infant was born before expected due date (i.e., 7 weeks).

REASON FOR REFERRAL
Identify a response by placing a checkmark (√) in the "YES" or "NO" column for each question item based on the client's or infant caregiver's report. There are two separate sections, one for maternity, and the other for infants. Only answer questions exclusive to the client being referred. At least one "YES" is indicative of reason for referral for risk screening. **Eligibility for program services is only determined via a risk screen performed by an MSDH nurse or outside medical provider.**

OTHER INFORMATION
Individual completing form may provide additional narrative information in this section. Additional needs can be noted here. Contact information for other supportive family members aware of the referral can be provided here.

MSDH STAFF USE ONLY
MSDH staff should note the date, time, and location in which the referral was received. Staff may also use this section to provide notes concerning the initial follow-up efforts, outcome, and future plans as it relates to the referral.

PROCESSING OF REFERRALS

1. Personnel from the referring agency, program or setting are responsible for ensuring referrals are returned to the HMHB Central Office either via U.S. Postal Service, secure fax, secure email (HM.HB@msdh.ms.gov), EPIC or other acceptable means.
2. Clinic staff should forward all referral forms to HMHB Central Office.
3. Case managers should attempt to make contact with the client within 7 days to discuss referral and offer assistance in scheduling an appointment for a risk-screening with a clinic nurse. Clients should also be advised of the clinic's walk-in policy. Case managers should document contact in EPIC record.
4. Case managers may use systems, such as WIC, EPIC, etc. to identify upcoming appointments clients may already have and coordinate accordingly for the client to also have a risk screening conducted at that time.

5. If client agrees to come in for a risk screening, case managers should mail appointment letter to a confirmed address and ask clinic clerk to provide text reminder of appointment to a confirmed phone number.
6. Case manager should follow-up to determine outcome of risk-screening appointment. If client failed to show, case manager is to follow-up with client on missed appointment and document in the EPIC record.
7. If client does show and screens positive for risk factors, the client should be offered HM/HB services and enrolled accordingly. HM/HB staff will follow-up to provide the discipline-specific assessments, develop a plan of care, etc. from that point. All information should be documented in the EPIC record.

OFFICE MECHANICS/FILING

The referral form should be scanned to EPIC and saved to the client's EPIC record.

For clients who are referred and participate in risk screening, but screen negative, such referrals are still to be scanned to EPIC and saved to the client's EPIC record. It should be properly documented by the case manager or Nurse providing the risk screen, the outcome of the referral.

For clients referred but despite sufficient efforts cannot be contacted to arrange a risk screening or who fail to attend/participate in risk screening, those referrals are to be scanned to EPIC and saved to the client's EPIC record. It should be properly documented by the case manager, the outcome of the referral.