Daviess Community Hospital
Perinatal Pathways

Perinatal Pathways Referral Form

Today's Date:	**REFERRING AGENCY/ORGANIZATION:**	
Referral From:	**Title:**	**Cell:**
Phone:	**Fax:**	**Mailing Address:**

MOTHER INFORMATION				
*** Last Name:**	*** First:**	*** Middle:**	*** D.O.B**	*** Race: Black ☐ White ☐ Hispanic ☐ Creole ☐ Other ☐**
***Address:**				
***City:**	***Zip code:**		***Home phone:**	***Cell:**
Is client married? Yes☐ No☐		**Best time to call:**		

REASON FOR REFERRAL (Check all that apply)		
☐ Teen mom *(18 and under)*	**☐ Someone hit/hurt mother in the last year**	**☐ Had baby that was not born alive**
☐ 2nd Trimester entry or no prenatal care	**☐ Postpartum depression**	**☐ Had baby born 3 weeks or more before due date**
☐ Pregnancy interval <18 months	**☐ Reported depression/hopelessness/stress**	**☐ Had baby weighing less than 5 lbs 8 oz**
☐ Has chronic medical condition	**☐ Homelessness**	
☐ Substance use/Smoked cigarettes in the last month	**☐ Other reason, specify :**	

INFANT INFORMATION				
*** Last Name:**	*** First:**	*** Middle:**	*** D.O.B**	*** Gender: Male ☐ Female ☐**
*** Address:**			*** Social Security #:**	
*** City:**	*** Zip code:**		*** Home phone:**	*** Cell:**

REASON FOR REFERRAL (Check all that apply)				
☐Poor birth outcome	**☐ Infant birth weight is less than 2000 grams (4 lbs 7 oz)**	**☐ Infant admitted to NICU**	**☐ Mother smoked/Substance use during pregnancy (exposed)**	**☐ Bonding concerns**
☐ Depression	**☐ Parenting stress**	**☐ Lack of resources**	**☐ Other reason, specify :**	

This form contains confidential client information and all HIPAA procedures need to be followed. Send referrals to: DCH Perinatal Pathways via fax at (812) 254-6679 or email to dlewis@dchosp.org and call (812) 254-2760, ext. 1333, to confirm receipt of referral.

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