mercy care

602-263-3000 or 1-800-624-3879

PERINATAL REFERRAL FORM

Please fax to 602-431-7552 or OBfaxes@aetna.com

Doctor's Name: _____ **Provider ID #:** _____

Doctor's Phone #:_____ **Doctor's Fax #:** _____

Mailing Address: _____

Office Contact Person: _____ **Extension #:** _____

Member's Name: _____ **Member's ID #:** _____

Member's telephone# _____ **Date of Birth:** _____/_____/_____ **Age:** ____**Primary Language:** _____

Pay To:_____ **Tax ID#**_____

LMP: _____/_____/_____

EDC: _____/_____/_____

Enrolled With:

- **WIC** Y ☐ N ☐
- **Baby AZ** Y ☐ N ☐

Other Insurance? Y ☐ N ☐

If Yes, Name of Primary Insurance

Mom's Choice of PCP for Baby

Dr. _____

Name of Hospital for Delivery

_____

Gravida: _____

Para: _____

# of Miscarriages_____

# of Stillbirths_____

# of Induced Abortions_____

Date of 1st Prenatal Visit

_____/_____/_____

No Show ☐

Current Medical Concerns With This Pregnancy?

Y ☐ N ☐

Explain: _____

_____

_____

Significant Past Medical Hx?

Y ☐ N ☐

Explain: _____

_____

_____

Hx of STD?

Y ☐ N ☐

Current/Hx of Illicit and or Prescription Opioid Use?

Y ☐ N ☐

Explain: _____

_____

Significant Social or BH Hx?

Y ☐ N ☐

Explain: _____

_____

_____

MERCY CARE PLAN USE ONLY

Date referral received:_____

Date triaged: _____

Date assigned for outreach: _____