



NOTIFICATION OF REFERRAL FOR HIGH RISK SERVICES

District #12 (Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, and Washington Counties)

Patient Name: _____

Medicaid #: _____ EDC: _____

Date of Birth: _____ Date of Referral: _____

The above patient has been referred to: _____
Facility Name

- For:
- High Risk Referral Clinic
 - Maternal – Fetal Medicine Clinic
 - Fetal Diagnostic Clinic
 - Genetics
 - USA Children’s and Women’s Hospital
- Via ambulance: Yes No

Appointment Date (if applicable): _____

Is patient expected to return to local provider for prenatal care? Yes No

Diagnosis: _____

DHCP Name: _____
(Print Name)

Signature: _____ Date: _____

**Fax ASAP: Gift of Life office at 334-272-4614
 Local Care Coordinator**