

NOTIFICATION OF REFERRAL FOR HIGH RISK SERVICES

Districts #6 & #10

*(Autauga, Bullock, Butler, Clay, Coosa, Crenshaw, Elmore, Lowndes,
Montgomery, Pike, Randolph, Talladega, & Tallapoosa Counties)*

Patient Name: _____

Date of 1st Prenatal Visit @ DHCP: _____

Medicaid #: _____ EDC: _____

Date of Birth: _____ Date of Referral: _____

- Assigned to _____ for **prenatal care** and **delivery**
- Referred to _____ hospital or clinic
 - Ambulance transport to _____ hospital
(Delivery Only or Pre-delivery Inpatient)
 - Appointment at (Complications Clinic / Genetics /
Other _____)
 - o Date of appointment _____
 - o At UAB USA *(Check One)*

Diagnosis: _____

DHCP Name: _____
(Print Name)

Signature: _____ Date: _____

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