Patient Advocacy Form

Dear Dr. ______________ and staff.

___________________________ (County Health Department/Hospital/Private Provider) would like to advocate for Perinatal Health Partners enrollment for

_______________________________.

(Patient Name)

Due to the following reason(s)/risk factor(s):

_____________________________________________________________

_____________________________________________________________

If you agree with our concerns and wish to enroll this patient in Perinatal Health Partners please complete the attached Referral/Consent form and forward it to your PHP nurse.

Thank you,

___________________________

(Patient Advocate)

___________________________

(Date)

Faxed to MD Yes or No
PERINATAL HEALTH PARTNERS  
Referral/Consent Form  
1003 Shirley Ave.  
Douglas, GA 31533  
Phone: 912-389-4623  
Fax: (912) 389-0189

Criteria may include but are not limited to the following:
- Miscarriage – Second Trimester Pregnancy Loss
- Previous Fetal/Neonatal Death (If baby dies due to prenatal complications).
- Diabetes – Gestational Type I or Type II
- Pre-term Labor
- Pre-existing Medical Conditions (i.e. Lupus, Auto-Immune Disease, Cardiac Disease, Epilepsy, HIV, STC.)

The following diagnosis will be considered on a case-by-case basis:
- Fetal Abnormality (Current pregnancy)
- Physician ordered Bed Rest

High Risk Diagnosis/Primary ICD-9 Code: ____________ EDC__________

Patient

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<thead>
<tr>
<th>First Name</th>
<th>Middle</th>
<th>Last Name</th>
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<tr>
<th>Date of Birth</th>
<th>Health Insurance</th>
<th>Phone (Work, Home, Message)</th>
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<td></td>
<td>Mcd</td>
<td>BBH</td>
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Mailing Address

| Physical Address /Directions

Parent/Guardian (If Patient is Infant or a Minor)

I, the patient/guardian, give my consent to be referred to the Perinatal Health Partners Nurse Home Visitation and/or the High Risk Consultation Clinic by my physician.

_________________________  _________________________
Patient Signature Date

Physician Recommendations for Nursing Care Plan:

_________________________  _________________________
Physician Signature Date