Office of Perinatal Health-Southeast Health District
1003 Shirley Ave.
Douglas, GA 31533
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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
Prior Premature Delivery or PROM
Incompetent Cervix
PIH – Pre-eclampsia
Multiple Gestation with Complications
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-10 Code:_____ EDC_____

Patient

First Name	**Middle**	**Last Name**
Date of Birth	**Health Insurance** **Mcd BBH Priv Ins None**	**Phone (Work, Home, Message)**
Mailing Address		**City Zip**
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:**

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