Health Plan of San Joaquin

Me & My Baby Program

Provider Notification/Referral Form

Please fax form to: **209.762.4720** | Referral Line: 209.942.6356

Date: ______________________

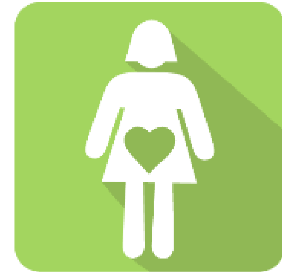
***Member's Name:** ______________________ DOB: ______________

***HPSJ ID:** ______________________ ***Primary Phone:** ______________

Preferred Language: ______________________

***Estimated Due Date:** ______________ ***Estimated Gestational Age:** ______________

***Select at least one of the following:**



- ☐ Pregnancy Notification Only (Non-High Risk)
- ☐ High Risk Pregnancy
  - ☐ History of:
    - ☐ Pre-term delivery
    - ☐ Miscarriage
    - ☐ Stillborn
  - ☐ Diabetes
  - ☐ Heart Disease
  - ☐ Multiple Gestation
  - ☐ Mental Health (including history of depression and/or Anxiety)
  - ☐ Social Determinants of Health
  - ☐ Substance Abuse
  - ☐ Smoker
  - ☐ Medical condition complication pregnancy: ______________________
- ☐ Prenatal Resource Information
  - ☐ Educational Materials
  - ☐ Resource List
  - ☐ Prenatal Classes
- ☐ Other: ______________________

Referring Provider's Name: ______________________

***Name of Referring Person:** ______________________

Address: ______________________

City: ______________ State: ________ Zip: ________

***Phone:** ______________ Office Contact: ______________