

Reference #:
Effective Date:
Thru Date:

**Neighborhood Health Plan
Medical Management Department
(401) 459-6675**

**Instructions: Please complete this form and fax back to Neighborhood at FAX: (401) 709-7035.
Please update the form and resend with any new information or risks associated with this pregnancy.
Pregnant members receive education from the Bright Start Program.**

The following information is required by DHS and necessary to obtain a reference number:

OB-GYN Name: _____ OB Site: _____ Fax: _____
Member ID: _____ Name: _____ DOB: _____
Member address: _____ Phone: _____
LMP: _____ 1st date of service: _____ EDD: _____
Gravida: ____ Para: ____ AB: ____ Living: ____

MEDICAL HRA - PLEASE CHECK ALL RISKS THAT APPLY*

NONE APPLY

- History of Pre-term delivery (less than 36 weeks GA) secondary to: _____
 Receiving weekly injections (17P): Yes _____ No _____ If no, exclusion reason: _____
 Current Diabetes Mellitus: Gestational _____ Non-Gestational _____
 Pre-existing HTN: _____ Current preeclampsia/eclampsia _____ On medication __Y__N__
 Health care non-adherence: Not following treatment plan _____ Not keeping apts. _____
 Short term pregnancy interval (< 12 months)
 Smoking

NEIGHBORHOOD REFERRAL FOR MEDICAL CASE MANAGEMENT

- No Yes, referral reason: _____
 Have you discussed the referral with your patient? Yes _____ No _____

BEHAVIORAL HEALTH HRA - PLEASE CHECK ALL RISKS THAT APPLY*

NONE APPLY

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Other BH issues: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Substance Abuse | |
| <input type="checkbox"/> History of post partum depression | <input type="checkbox"/> Suicidal attempts | <input type="checkbox"/> History of PTSD |

BEACON REFERRAL FOR BEHAVIORAL HEALTH CASE MANAGEMENT

- No Yes, referral reason: _____

Consent Signatures for a Beacon Referral are required. Consent Date: _____

Patient Signature: _____ Provider Signature: _____

Consent Signatures confirm the Provider has discussed the referral with the patient and the patient has consented to telephonic contact by a case manager from Beacon Health Strategies. Beacon referrals can also be made at anytime with or by the patient by calling Beacon directly at (401)-459-6681.

*** Risks checked off or written on this form do not ensure enrollment into the Bright Start Case Management Program. Neighborhood assumes the provider is managing all risks identified on this form.**