Mississippi State Department of Health Perinatal High Risk Management/ Infant Support System (PHRM/ISS) Referral (Maternity or Infant)	# FOR USE BY NON-MEDICAL/ NON-MSDH SETTINGS ONLY

Referral Source

Referring agency: ______________________________ Date: ______________

Individual completing referral: ______________________________ Title: ______________

Mailing address: ______________________ City: ____________ State: _____ Zip: ________

Phone: ______________________ Fax: ______________________

Client Information – (Circle one MATERNITY or INFANT)

Client Full Name	DOB	Age	Medicaid #	
Caregiver's Name/Relationship (for INFANT/MINOR)	Home #		Cell #	
Physical Address	County	City	State	Zip

Pregnancy Information (for MATERNITY referral only)

Expected Due Date	Date of First Prenatal Doctor's Visit	Maternity Care Provider (Name, Contact Information)

Birth/Medical Information (for INFANT referral only)

Birth Weight	Was baby born before expected due date?	Infant's Doctor (Name, Contact Information)
lbs. oz.	Yes No If yes, by how many weeks?	

		Reason for Referral (for MATERNITY referral only)
Yes	No	Indicate "YES" or "NO" for any of the following per the infant caregiver's report:
		Client is 17-19 years old.
		Client is 16 years old or younger.
		Client has experienced pregnancy loss or pregnancy termination in the past.
		Client has had a baby born more than 3 weeks early.
		Client's due date is less than 14 months since her last pregnancy ended.
		Client started prenatal care after several months of being pregnant.
		Client has an illness that requires ongoing medical care.
		Client has had problems with current pregnancy.
		Client has been told this baby may have birth defects or other problems.
		Client takes medication to keep her from going into labor.
		Client has been placed on bed rest at some point this pregnancy.
		Client's pregnancy is managed by a specialist.

Client Full Name: ______________________________ DOB: ____________

		Reason for Referral (for INFANT referral only)
Yes	No	Indicate "YES" or "NO" for any of the following per the infant caregiver's report:
		Mother of infant is 17-19 years old.
		Mother of infant is 16 years old or younger.
		Mother had limited prenatal care before delivery.
		Infant stayed in the intensive care/critical care nursery after birth.
		Infant was born with birth defect(s) or other problems.
		Infant has a diagnosed medical condition requiring ongoing medical management.
		Infant was born more than 3 weeks early.
		Infant sees a specialist to manage a medical condition.
		Infant sees a developmental specialist or clinic to monitor growth and development.

Other Information

By signing this referral, I authorize the referring agency named above to release this information to the Mississippi State Department of Health for the purposes of determining my/my infant's eligibility for a risk screening for enrollment in the Perinatal High Risk Case Management/Infant Support Systems program. I understand that MSDH program staff will contact me to collect further information and arrange a screening at no cost to me or the referring agency. I understand that I may revoke my consent at any time except to the extent that action has already been taken. I further understand that this consent will expire upon my written request or automatically ninety (90) days from the date beside my signature below, and cannot be renewed without my written consent.

______________________________ ______________

Client Signature/Authorized Caregiver Signature Date

______________________________ ______________

Witness Signature Date

This form should be submitted to the county health department nearest the client's place of residence. For a complete listing of health department locations,visit https://healthyms.com/ or call 1-800-721-7222

MSDH PHRM/ISS Staff use Only

Perinatal High Risk Management/Infant Services System
Referral Form 74 Instructions

Purpose
The purpose of the Perinatal High Risk Management/Infant Services System (PHRM/ISS) Referral Form is to allow non-medical settings to participate in identifying pregnant women and infants up to one year old, who may be eligible for the Mississippi Department of Health PHRM/ISS case management program and who may not otherwise be identified or referred through a medical or MSDH setting.

Instructions
1. The form should be completed for pregnant women/infants up to 12 months old, who may benefit from a risk screening to determine eligibility or rule-out qualifying risks for the PHRM/ISS case management program.
2. This form is to be used by personnel in non-medical settings, such as schools, colleges, social service agencies, youth-serving organizations, child care centers, faith-based programs/communities, justice system/detention centers, child welfare settings, and mental health settings.
3. **MSDH personnel and healthcare providers** are directed to **continue** using the Division of Medicaid approved Maternity and Infant Risk Screens, revised 09/30/2015. Refer to the instructions specific to this form available on the MSDH website at: http://msdh.ms.gov/msdhsite/_static/41,0,106.html
4. Referrals should be made/sent directly to the County Health Department in or nearest the client's county of residence attention **PHRM/ISS Case Manager**.

Please print the requested information in each blank (* indicates required information)

REFERRAL SOURCE
Referring agency*: Enter the name of the agency or setting initiating the referral on the client's behalf
Date*: Enter the date the agency initiates the referral to MSDH
Individual completing form*: Enter the name of the individual from the agency completing the referral
Title*: Enter the title or position the individual completing the form has at the referring agency
Mailing address*: Enter the mailing address for the referring agency
City*: Enter the city where the referring agency is located
State*: Enter the state the where the referring agency is located
Phone*: Enter a telephone number for the individual completing the form at the referring agency
Fax*: Enter a fax number for the individual completing the form at the referring agency

CLIENT INFORMATION – "Client" is indicative of the pregnant woman or infant being referred.
Full Name*: Enter the client's first, middle (if known), and last name
DOB*: Enter the client's date of birth (mm/dd/yyyy)
Age*: Enter the client age in completed years
Medicaid #*: Enter the client's nine digit Medicaid number
Caregiver's Name/Relationship (for INFANT/MINOR)*: Enter name of primary caregiver for any infant client who is referred by an outside agency. Outside agencies may also enter caregiver information for minor clients here as well, though it is not required by MSDH.
Home #*: Enter the home phone number for the client
Cell #*: Enter the cell phone number for the client
Physical Address*: Enter the client's physical address (no Post Office Box addresses)
County*: Enter the county that the client resides in
City*: Enter the city that the client resides in

State: Auto-Fill with MS (Mississippi)
Zip*: Enter the zip code for the client's address that was provided

PREGNANCY INFORMATION (for MATERNITY referral only)
Expected Due Date*: Enter the expected due or delivery date based on the client's self-report
Date of First Prenatal Doctor's Visit*: Enter the date of the first prenatal care appointment based on client's self-report; if no prenatal care appointment has been initiated, enter "0"
Maternity Care Provider*: Enter the name of provider/clinic the client sees for maternity/prenatal care. Enter contact information (address, phone number) if available.

BIRTH/MEDICAL INFORMATION (for INFANT referral only)
Birth Weight*: Enter infant's birth weight using numbers for pounds (lbs) and ounces (oz).
Was baby born before due date?* YES NO: Circle YES if infant was born before expected due date. Circle NO if infant was born close, on, or after expected due date.
If yes, by how many weeks? __*: Write in the blank area the number of weeks infant was born before expected due date (i.e., 7 weeks).

REASON FOR REFERRAL
Identify a response by placing a checkmark (√) in the "YES" or "NO" column for each question item based on the client's or infant caregiver's report. There are two separate sections, one for maternity, and the other for infants. Only answer questions exclusive to the client being referred. At least one "YES" is indicative of reason for referral for risk screening. **Eligibility for program services is only determined via a risk screen performed by an MSDH nurse or outside medical provider.**

OTHER INFORMATION
Individual completing form may provide additional narrative information in this section. Additional needs can be noted here. Contact information for other supportive family members aware of the referral can be provided here.

CONSENT STATEMENT
Consent statement should be reviewed with client, who should be given opportunity to ask any questions before signing. The client should sign consent and date it. The individual completing the referral form should sign as the "witness" and date it.

MSDH PHRM/ISS STAFF USE ONLY
MSDH staff should note the date, time, and location in which the referral was received. Staff may also use this section to provide notes concerning the initial follow-up efforts, outcome, and future plans as it relates to the referral.

PROCESSING OF REFERRALS

1. Personnel from the referring agency or setting are responsible for ensuring referrals are returned to an MSDH clinic either via U.S. Postal Service, secure fax, or other acceptable means.
2. Clinic staff should forward all referral forms to a clinic PHRM case manager.
3. Case managers should attempt to make contact with the client within 14 days to discuss referral and offer assistance in scheduling an appointment for a risk-screening with a clinic nurse. Clients should also be advised of the clinic's walk-in policy.
4. Case managers may use systems, such as WIC, PIMS, etc. to identify upcoming appointments clients may already have and coordinate accordingly for the client to also have a risk screening conducted at that time.

5. If client agrees to come in for a risk screening, case managers should ask clerk staff to mail appointment letter to a confirmed address and provide text reminder of appointment to a confirmed phone number.
6. Case manager should follow-up to determine outcome of risk-screening appointment. If client failed to show, case manager is not obligated to provide any additional follow-up, but may elect to do so based on referral information, MSDH client history, or other information.
7. If client does show and screens positive for risk factors, the client should be offered PHRM/ISS services and enrolled accordingly. PHRM/ISS staff will follow-up to provide the discipline-specific assessments, develop a plan of care, etc. from that point.

OFFICE MECHANICS/FILING

The referral form should be made part of the chart if the client enrolls in PHRM/ISS and should be filed behind the risk screen completed by a MSDH nurse.

For clients who are referred and participate in risk screening, but screen negative, such referrals are to be kept separate. A copy should be returned to the District SSRD and/or District PHRM Coordinator.

For clients referred but despite sufficient efforts cannot be contacted to arrange a risk screening or who fail to attend/participate in risk screening, those referrals are to be kept separate. A copy should be returned to the District SSRD and/or District PHRM Coordinator. In addition, case managers are instructed to use the CCO Form 226 to provide an abbreviated account of the effort provided toward the referral and outcome.