REFERRAL TYPE:

PRENATAL _____ INFANT _____

Baby Care Referral Form

Baby Care is a Medicaid-based RN home visiting program for pregnant women and infants up to 2 years of age.

Date of Referral: _____

Client's Name :_____

Mother's Name (if referral is an infant):_____

Client's Date of Birth: _____ EDC: _____

Phone Number(s): (H): _____ (C): _____

911 Address: _____

Client's Physician(s) – OB or Primary: _____

Referral Source (Agency/Name): _____

Referral Source Phone Number: _____

Reason for Referral: _____

_____ Please check if client is a pregnant teen aged 19 or younger.

Please fax referral form to numbers as listed below or call if you have any questions. Thank you.

You may refer online at: https://redcap.vdh.virginia.gov/redcap/surveys/?s=P8RLJTHTKX

PLEASE FAX REFERRAL FORMS TO MARY ANNE HALL, BABY CARE NURSE SENIOR AT 276-730-3185

OFFICE TELEPHONE: 276-730-3180
WORK CELLPHONE: 276-685-0026

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