 **TINY BLESSINGS MATERNAL NEWBORN HOME HEALTH**

**MERCY HOME HEALTH**

**POSTPARTUM/NICU REFERRAL FORM**

**Referral is for:** **☐ Mom & Baby ☐ Mom only ☐ Baby only**

**☐ Please check box if Patient’s Insurance is an IBC Product – (IBC/Keystone Health Plan East/Personal Choice) All IBC must be a Mom & Baby Referral – Baby Only Cannot be Accepted under IBC**

**CI Process First and Enter as “Routine” Care Type with ICD-10 code Z39.2 for Mom and Z76.2 for Baby**

**All Health Partners Patients Must Have a Script – CI Enter as High Priority Care Type**

Referring Facility: \_\_ST CHRIS’ CENTER FOR THE URBAN CHILD\_\_\_\_\_\_\_ Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Sending Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_

Patient's Last Name: \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apartment Number: \_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ SVD ☐C/S ☐ Male ☐Female GTPAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discharge Date:** **\_\_\_\_\_\_\_\_\_\_\_** Birth Wt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Wt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby's REAL Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Baby born at what gestational age: \_\_\_\_\_\_\_\_\_\_

Obstetrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Routine Mom Diagnosis Routine Newborn Diagnosis**

☐ Routine Mom (Z39.2) ☐ Routine baby (Z76.2)

☐ Postpartum Hemorrhage (O72.2)

☐ Endometritis (O86.12) **BILIRUBINS** **– High Priority** **Diagnosis**

☐ Gestational Diabetes Mellitus (O24.439) **☐ Bilirubin Level Jaundice (P59.9)**

☐ COVID Positive Testing Date: \_\_\_\_\_\_\_\_\_\_\_ (U07.1) **Date of bili draw:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Prescription required for ALL Bilirubins – will need high priority care type (Except IBC Insured)**

**High Priority Mom Diagnosis (Except IBC Insured)** **High Priority Newborn Diagnosis** **(Except IBC Insured)**

☐ Cognitive Deficit (R41.841) ☐ NICU Baby D/C Date: \_\_\_\_\_\_\_\_\_\_

☐ Drug Dependence (O99.234) ☐ Weight Check/Feeding Problems of Newborn: (P92.9)

☐ Hypertension (O16.5) Date needed: \_\_\_\_\_\_\_\_\_\_\_

☐ Pre-Eclampsia (O14.95) ☐ NAS baby (P96.1)

☐ Lovenox/Coagulation Defects/Blood Clots (O72.3) ☐ Bronchopulmonary Dysplasia/BPD (P27.1)

☐ Symphysis Pubis (O26.73) ☐ Hypoxic Ischemic Encephalopathy/HIE (P91.60)

 ☐ Neonatal Hypoglycemia (P70.4)

 ☐ Preterm Newborn (P07.30)

Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE FAX COMPLETE FORM AND ANY REQUIRED PRESCRIPTION TO**

**MERCY INTAKE: 610-271-9559**