Patient Advocacy Form

Dear Dr. ___________________ and staff.

_________________________ (County Health Department/Hospital/Private Provider) would like to advocate for Perinatal Health Partners enrollment for

_______________________________.

(Patient Name)

Due to the following reason(s)/risk factor(s):

________________________________________

________________________________________

________________________________________

If you agree with our concerns and wish to enroll this patient in Perinatal Health Partners please complete the attached Referral/Consent form and forward it to your PHP nurse.

Thank you,

_________________________

(Patient Advocate)

_________________________

(Date)
Criteria may include but are not limited to the following:

Miscarriage – Second Trimester Pregnancy Loss

Prior Premature Delivery or PROM

Previous Fetal/Neonatal Death (If baby dies due to prenatal complications).

Incompetent Cervix

Diabetes – Gestational Type I or Type II

PIH – Pre-eclampsia

Pre-term Labor

Multiple Gestation with Complications

Pre-existing Medical Conditions (i.e. Lupus, Auto-Immune Disease, Cardiac Disease, Epilepsy, HIV, STC.)

The following diagnosis will be considered on a case-by-case basis:

Fetal Abnormality (Current pregnancy)

Physician ordered Bed Rest

High Risk Diagnosis/Primary ICD-9 Code: _____________ EDC ___________

Patient

<table>
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<tr>
<th>First Name</th>
<th>Middle</th>
<th>Last Name</th>
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Date of Birth

Health Insurance

Mcd    BBH    Priv Ins    None

Phone (Work, Home, Message)

Mailing Address

City    Zip

Physical Address /Directions

Parent/Guardian (If Patient is Infant or a Minor)

I, the patient/guardian, give my consent to be referred to the Perinatal Health Partners Nurse Home Visitation and/or the High Risk Consultation Clinic by my physician.

________________________  _______________________
Patient Signature         Date

Physician Recommendations for Nursing Care Plan:

________________________  _______________________
Physician Signature       Date