

**FORWARDHEALTH
PRENATAL CARE COORDINATION REFERRAL**

INSTRUCTIONS: Type or print clearly. Prenatal care coordination (PNCC) providers use referrals to give members current information about available providers, community resources, and programs to help connect the member to services they need that were identified in the member's care plan. Providers can use this optional form for record-keeping and for sharing information with the member. For more information, refer to the Key Prenatal Care Coordination Requirements section of the Prenatal Care Coordination service area of the ForwardHealth Online Handbook at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=54>.

The Authorization section of this form does not replace the need for a consent document to release member information.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Date of Birth – Member

3. Member Medicaid ID Number

4. Phone Number – Member

5. Date of Referral

6. Address – Member (Street, City, State, and Zip Code)

SECTION II – REFERRAL INFORMATION

7. Name – Provider Being Referred To

8. Phone Number – Provider Being Referred To

9. Address – Provider Being Referred To (Street, City, State, and Zip Code)

10. Name – Referring PNCC Provider

11. Name – Referring Care Coordinator

12. Phone Number – Referring Provider

13. Address – Referring Provider (Street, City, State, and Zip Code)

14. Reason for Referral

SECTION III – AUTHORIZATION

15. I, _____ (Member Name), give my permission to _____ (Name of Referring Provider) to release this information to _____ (Name of Provider Being Referred To). My providers will use this information to connect me to resources and services that can help me manage my health care and social service needs.

16. **SIGNATURE** – Member / Parent or Guardian

17. Date Signed – Member / Parent or Guardian

SECTION IV – RECORD REFERRAL ACTIVITIES

18. Reply From Provider Being Referred To (Summary of Referral Findings, Diagnoses, Recommendations, Comments, or Provider Follow-up if Needed)

19. **SIGNATURE** – Referring Care Coordinator

20. Date Signed – Referring Care Coordinator

21. Name – Referring Care Coordinator (Print)

22. Name – Referring PNCC Provider Agency (Print)
