High-Risk Pregnancy Referral Form

Instructions: Please provide this referral form and relevant patient records/ACOG forms using HIPAA required safeguards via fax to (518) 641-3303 or via e-mail to pregnancy@cdphp.com.

CDPHP depends on timely notification of pregnancy to provide your patients with resources and education to support them with a healthy pregnancy. Additionally, CDPHP offers case management services for high-risk pregnancies to provide continuity of care, improve the quality of maternity care, and improve birth outcomes.

Demographic Information

Member Name: _____

Member Identification #: _____

Member Date of Birth: _____

Referring Physician: _____

Member Phone #: _____

Member EDD: _____

High-Risk Pregnancy Referral Reason *(Check all that apply)*

- ◯ Hx of Preterm Birth (less than 37 weeks)
- ◯ Current Tobacco or Substance Use
- ◯ Depression or Anxiety
- ◯ Teen Pregnancy (Under age 18)
- ◯ Hx of Domestic Violence or Unstable Housing
- ◯ Rh Incompatibility
- ◯ Obesity
- ◯ High Blood Pressure
- ◯ HIV/AIDS
- ◯ Cardiac Conditions
- ◯ Diabetes
- ◯ Asthma
- ◯ Neurologic Disorder
- ◯ Other: _____

Notes/Comments:

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REMINDER: Please be sure to attach patient records or ACOG forms.

Confidential Patient Information