



**RIGHT FROM THE START PROGRAM
ALTERNATE ENTRY REFERRAL OF INFANTS/PRENATALS TO RFTS***



*Infant's Name: _____
(Last) (First) (MI)

SSN: _____

Birth Score ID #: _____

Hospital of Delivery: _____

*Date of Birth: ___/___/___ Sex: Female Male

Birth Weight: _____ Birth Score: _____

*Mother/Guardian Name: _____

Address: _____

Mother/Guardian SSN: _____

Mother/Guardian DOB: _____ County: _____

Telephone: _____

Medicaid Number: _____

Child Mother/Guardian Effective Date: _____

HMO Plan: _____

HMO No.: _____

Effective Date: _____

Name & Address of Physician: _____

Telephone: _____

Concerns: _____

Newborn Hearing Screening
 Pass Fail Unknown

*Prenatal Name: _____
(Last) (First) (MI)

SSN: _____

Address: _____

Telephone: _____

*Date of Birth: ___/___/___

EDC: ___/___/___

County: _____

RFTS Maternity Services Medicaid Insurance

RFTS/Medicaid No.: _____

Effective Date: _____

HMO Plan: _____

HMO No.: _____

Effective Date: _____

Name & Address of Physician: _____

Telephone: _____

Concerns: _____

Referral Closure Codes (For DCC Use) Date: _____

- | | |
|---|---|
| <input type="checkbox"/> B-01 Spontaneous Abortion | <input type="checkbox"/> B-06 Unable to Establish contact |
| <input type="checkbox"/> B-02 Induced Abortion | <input type="checkbox"/> B-07 Refused Services |
| <input type="checkbox"/> B-03 Moved out of state | <input type="checkbox"/> B-08 Death |
| <input type="checkbox"/> B-04 Transferred out of region | <input type="checkbox"/> B-14 Did not meet eligibility |

Protective Service Referral: _____ Case Worker: _____

Referred to RFTS by: _____ Date: _____

Site: _____ Telephone: _____

Date Received: _____ Date of Approval: _____

Referred to (DCC Agency): _____

Recommendations: _____

Signature: _____ Date: _____
(Regional Care Coordinator)

DCC is to return a copy of form to RCC with appropriate code checked if unable to complete the Initial Client Assessment (R036)

* Required fields