OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
RIGHT FROM THE START PROGRAM
REFERRAL OF INFANTS/PRENATALS TO RFTS

Infant Name: _____
Last First MI

SSN: _____

Hospital of Delivery: _____

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

Mother/Guardian Name: _____

Address: _____

_____

Mother/Guardian SSN: _____

Mother/Guardian DOB: ___/___/___

County: _____

Telephone: _____

Medicaid #: _____

Effective Date: ___/___/___

❑ **Child** ❑ **Mother/Guardian**

MCO Plan: _____

MCO #: _____

Effective Date: ___/___/___

Name & Address of Physician:

_____

_____

_____

Telephone: _____

Concerns: _____

_____

_____

Prenatal Name: _____
Last First MI

SSN: _____

Address: _____

_____

Telephone: _____

DOB: ___/___/___

EDC: ___/___/___

County: _____

❑ **RFTS Maternity Services** ❑ **Medicaid** ❑ **Insurance**

RFTS/Medicaid #: _____

Effective Date: ___/___/___

MCO Plan: _____

MCO #: _____

Effective Date: ___/___/___

Name & Address of Physician:

_____

_____

_____

Telephone: _____

Concerns: _____

_____

_____

_____

_____

_____

_____

Child Protective Services Referral: _____

Case Worker: _____ **Telephone:** _____

Referred to RFTS by: _____ **Date:** ___/___/___

Site: _____ **Telephone:** _____

Date Received: _____ **Date of Approval:** ___/___/___

Referred to (DCC Agency): _____

Recommendations: _____

Signature: _____ **Date:** ___/___/___
(Regional Care Coordinator)

***SEPARATE FORMS FOR MULTIPLE BIRTHS**
WVDHHR/BPH/OMCFH/DPWH/PP/RFTS-R019
Revised: 08/2016

White:RCC
Yellow:DCC
Pink:HMO
Goldenrod:RCC