West Virginia Department of Health and Human Resources

Right From the Start Referral Form

Prenatal Referral

RFTS Maternity Services #: _____

Date: _____ County: _____ Phone: _____ Physician: _____

Prenatal Name: _____ SSN: _____ DOB: _____

Address: _____ EDC #: _____

Medicaid #: _____ MCO: _____ MCO #: _____

Comments: _____

Infant Referral

MULTIPLE BIRTHS WILL REQUIRE SEPARATE FORMS

Date: _____ County: _____ Phone: _____ Physician: _____

Infant Name: _____ SSN: _____ DOB: _____

Guardian Name: _____ SSN: _____ DOB: _____

Address: _____ ☐ Male ☐ Female

Medicaid #: _____ MCO: _____ MCO #: _____

Comments: _____

_____

Referring Agency

Agency Name: _____ Contact Name: _____

Phone: _____ Fax: _____ Email: _____

Received by Regional Care Coordinator

Date Received: _____ Date Approved: _____ DCC: _____

DCC Agency Referred to: _____

Phone: _____ Fax: _____ Email: _____

Signature: _____ Date: _____

(Regional Care Coordinator Address Label Attached Here)

Office of Maternal, Child & Family Health
Right From The Start
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Charleston, WV 25301
https://www.wvdhhr.org/rfts/