WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH
Office of Maternal, Child and Family Health

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
350 Capitol Street, Room 427
Charleston, WV 25301
https://www.wvdhhr.org/rfts/

WVDHHR/BPH/OMCFH/DPWH/PP/RFTS-R019
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