Kelly J. Townsend MAS-IFP

Medicaid Doula Provider (Washington, DC)

NPI: 1184482515

Doula Services Referral Form

DATE _____/_____/_____

Patient Information:

- Full Legal Name

- Medicaid ID Number

- Date of Birth:

- Phone Number

- Email Address

- Home Address

Preferred Language

Race/Ethnicity

Pregnancy Details:

- First Day of Last Menstrual Period (LMP)

- Estimated Due Date (EDD)

- Number of gestational weeks at time of referral

- Primip / Multip ***(Circle one)***

- Planned Delivery Location

- High Risk? Yes / No (Circle one)

Healthcare Provider Information:

- Provider's Name / Credentials

- Provider's Practice

- Provider's Contact

- Managed Care Organization (MCO) Name

- Type of provider (Midwife, OB/GYN/Clinic

Risk Factors (Hypertension, diabetes, mental health, VBAC, complications, etc)

Consent:

I, _____ (patient's name), authorize the release of the above non-clinical information between my healthcare provider and my doula solely for the purposes of coordinating maternity support services. I understand that a doula does not provide medical, midwifery, or nursing care.

Patient's Printed Name

Patient's Signature

Date signed

/ /

Please return this form to:

AmericanFamilyCenter@yahoo.com