

# 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***