# California's Perinatal Hub

## Provider Referral Form

For medical providers referring patients to perinatal support services

**Items with an asterisk (*) are required fields**

### Patient Information

Patient Name:* _____

Date of Birth:* _____ Primary Phone #:* _____

Best Time to Contact:* _____ Preferred Language:* _____

Email: _____

Address:* _____

Health Plan / Medi-Cal Plan: _____ Member ID #: _____

### Pregnancy Information

Status:* ☐ Currently pregnant ☐ Postpartum (up to 12 months)

Due Date / Delivery Date:* _____ Expected Birth Location: _____

First pregnancy: ☐ Yes ☐ No

### Services Requested

Check all that apply:

☐ Doula support ☐ Lactation support ☐ Perinatal mental health

☐ Childbirth / parenting education ☐ Care coordination / navigation ☐ Community resources

Other: _____

Reason for Referral / Relevant Clinical Notes:

Cultural / Religious Considerations: _____

### Referring Provider Information

Referring Provider Name:* _____ Referral Date:* _____

Practice / Agency:* _____ NPI # (if applicable): _____

Phone Number:* _____ Email Address:* _____

☐ Patient has agreed to this referral and to be contacted by California's Perinatal Hub.*

Questions about this referral? Call California's Perinatal Hub at 530-520-0928.