North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

North Carolina Baby Love Plus Program Referral

1. Last Name **First Name** **MI**

2. Date of Birth (MM/DD/YYYY) Month Day Year

3. Race
☐ 1. American Indian/Alaska Native ☐ 2. Asian
☐ 3. Black/African American ☐ 4. Native Hawaiian/OPI
☐ 5. White ☐ 6. Unknown
Ethnicity Hispanic/Latino Origin? ☐ Yes ☐ No ☐ Unknown

4. Gender ☐ 1. Female ☐ 2. Male

5. County ☐ Edgecombe ☐ Forsyth ☐ Guilford ☐ Halifax ☐ Nash ☐ Pitt

6. English Speaking? ☐ Yes ☐ No

7. Income Level? ☐ <100% of FPL ☐ 100–185% of FPL ☐ Income is Unknown ☐ Other _____

8. Insurance Status:

Medicaid (Title XIX)	☐
NC Health Choice (Title XXI)	☐
None	☐
Private/Other	☐
Unknown	☐

9. Does the patient use CHC or FQHC for Primary Care including Prenatal Care? ☐ Yes ☐ No

10. Week (Trimester) of Entry into Prenatal Care: _____

11. Number of Completed Prenatal Visits: _____

12. Did the patient receive at least one OBCM home visit during her pregnancy? ☐ Yes ☐ No

13. Was the patient assisted by a FOW during her pregnancy? ☐ Yes ☐ No

14. Did the patient receive NC BLP, Medicaid or other transportation services during her pregnancy? ☐ Yes ☐ No

15. Did the patient receive translation services during her pregnancy? ☐ Yes ☐ No

16. Was the father of the baby/partner involved in and supportive of patient during her pregnancy? ☐ Yes ☐ No ☐ Unknown

17. Did the patient complete a postpartum clinic visit? ☐ Yes ☐ No

18. Does the patient have a medical home after the postpartum period? ☐ Yes ☐ No

19. Did patient initiate breastfeeding? ☐ Yes ☐ No

20. Is patient enrolled in WIC? ☐ Yes ☐ No

21. Did patient receive services for treatment of perinatal depression? ☐ Yes ☐ No

22. Patient's Home Address: _____
_____
Patient's Telephone Number: _____
Directions to Home: _____
_____

23. Infant's Name Last First MI

24. Infant's Date of Birth (MM/DD/YYYY) Month Day Year

25. Infant's Birth Weight: _____ lbs. _____ oz.
Check One: ☐ Single Birth ☐ Multiple Birth

26. Gestational Age at Time of Delivery: _____

27. Delivery Hospital: _____

28. Did delivery prior to 39 weeks occur due to a non-medical reason? ☐ Yes ☐ No

Screening Questions

29. Did the patient smoke or use tobacco at all while pregnant? ☐ Yes ☐ No

30. Did the patient smoke or use tobacco during the last 3 months of pregnancy? ☐ Yes ☐ No

31. OBCM case status at time of referral *(check one)*: ☐ OB Light ☐ OB Medium ☐ OB Heavy

32. North Carolina Baby Love Plus Risk Indicators

(Please select one or more risk factors that the patient experienced during OBCM enrollment)

☐ Chronic medical conditions, including obesity
☐ Substance use during pregnancy
☐ History of prenatal or postpartum depression or other mental health diagnosis
☐ Sexually transmitted infection during pregnancy
☐ Short birth interval
☐ Tobacco use or exposure during pregnancy
☐ Lack of social support
☐ Recent history of intimate partner violence
☐ Other (please specify): _____

Comments:

33. Name of Person Completing This Form/Referral Source:
_____
Phone Number _____
Email Address _____

Disposition

Date Referral Received from OBCM Program: _____ (MM/DD/YYYY)
Date Referral Given to FCC: _____ (MM/DD/YYYY)
Name of FCC: _____
Date Participant Enrolled in NC BLP: _____ (MM/DD/YYYY)
Date Participant Declined NC BLP Services: _____ (MM/DD/YYYY)

Instructions For:
North Carolina Baby Love Plus Program
Referral

Purpose: To identify and refer all eligible women into the North Carolina Baby Love Plus Program.

Instructions:

Left side of form

1. **Name:** Print the last name, first name and middle initial of each patient (mom) screened by the OBCM.
2. **Date of Birth:** Print patient's month, day and year of birth.
3. **Race/Ethnicity:** Ask the patient to self identify what her race is. Also, ask the patient if she is of Hispanic origin or not.
4. **Gender:** Select as appropriate.
5. **County:** Select as appropriate.
6. **Language:** Select "Yes" if patient is English speaking or "No" if translator is required.
7. **Income Level:** Select as appropriate.
8. **Insurance Status:** Select as appropriate.
9. **CHC or FQHC:** Select "Yes" if the patient used a Community Health Center or Federally Qualified Health Center for Primary Care or Prenatal Care. Check "No" if she did not.
10. **Week/Trimester of Entry into PNC:** Enter number of the week that prenatal care began; enter the trimester (1st, 2nd or 3rd) when the patient started prenatal care.
11. **Number of Prenatal Visits:** Enter the number of visits completed during pregnancy by the patient.
12. **OBCM home visit during pregnancy:** Enter "Yes" if at least one visit was completed by a OBCM; check "No" if no visit was completed.
13. **Family Outreach Worker Assistance:** Check "Yes" if patient received help from an FOW; check "No" if patient was not assisted by an FOW.
14. **Transportation Services:** Check "Yes" id the patient received transportation services (Medicaid, local health department, NC Baby Love Plus or other) during her pregnancy. Check "No" if patient did not.
15. **Translation Services:** Check "Yes" if patient received translation services during her pregnancy. Check "No" if she did not.
16. **Father of the Baby/Partner Involvement:** Check "Yes" if the father of the baby or male partner was involved in the patient's life during pregnancy. Check "No" if father of the baby or male partner was not involved. Check "unknown" if information is not available or patient refuses to provide a response to question.
17. **Completion of Postpartum Visit:** Check "Yes" if patient completed her postpartum visit. Check "No" if patient did not complete her postpartum visit or if appointment has not occurred yet.
18. **Medical Home:** Check "Yes" if patient has a medical home after the postpartum period. Check "No" if patient does not have a medical home.
19. **Initiation of Breastfeeding:** Check "Yes" if patient initiated breastfeeding; check "No" if patient is not breastfeeding.
20. **WIC:** Check "Yes" if the patient is receiving WIC; check "No" if the patient is not receiving WIC.
21. **Treatment for Perinatal Depression:** Check "Yes" if patient received treatment; check "No" if patient did not receive treatment for perinatal depression.
22. **Patient Address/Phone Number/Directions to Home:** Print address where patient presently resides; include phone number(s) where patient can be reached and direction information to residence.

Right side of form

23. **Infant's Name:** Print complete name of infant-last name, first name and middle initial (if known). If a multiple gestation, include both names.
24. **Infant's Date of Birth:** Print address where patient presently resides; include phone number(s) where patient can be reached and direction information to residence.
25. **Infant Birth Weight/Single or Multiple Birth:** Print number of pounds and ounces of infant as indicated on form. Also, indicate (check) whether birth was a single or multiple birth.
26. **Gestational Age at Time of Delivery:** Indicate the number of weeks gestation the infant was at time of delivery**.**
27. **Delivery Hospital:** Print name of hospital, birthing center or other location (i.e., home) where infant was delivered at.
28. **Delivery prior to 39 weeks:** Check "Yes" if infant was delivered BEFORE 39 weeks for a non-medical reason (elective delivery); check "NO" if infant was not delivered prior to 39 weeks for a non-medical reason.
29. **Tobacco use during pregnancy:** Check "Yes" if patient smoked during pregnancy. Check "No" if patient did not smoke during pregnancy**.**
30. **Tobacco use during last 3 months of pregnancy:** Check "Yes" if patient used tobacco or tobacco products during the last 3 months of pregnancy. Check "No" if patient did not use tobacco or tobacco products.
31. **OBCM case status:** Check the (ONE) OBCM case status of the patient at the time of the referral to NC Baby Love Plus.
32. **NC Baby Love Plus Risk Indicators:** Select 1 or more risk indicators that the patient experienced during pregnancy and/or at the time of referral to NC Baby Love Plus. **Comments:** Include any relevant information about patient as needed.
33. **Name of Person Completing Referral Form:** Print name and contact information of the person completing this form.

Disposition: This section is to be completed by the local NC BLP Supervisor. Indicate the date the referral is received from the OBCM program. Indicate the date the referral is given to the Family Care Coordinator/Family Outreach Worker team. Print the name of the FCC that the participant will be assigned to. Indicate the date the participant enrolled into NC BLP (MM/DD/YYYY). Indicate the date the participant declined NC BLP services (MM/DD/YYYY). This form is to be retained in accordance with the records disposition schedule of medical records as issued by the North Carolina Office of Archives and History, Division of Historical Records.