



Maternal and Infant Health Outcomes Program MEMBER REFERRAL FORM

Use this form to refer a CCH member for maternal and infant health support, care coordination, resource navigation, or assistance addressing barriers to care. * PLEASE FILL OUT THOROUGHLY *

URGENT MEDICAL OR BEHAVIORAL HEALTH CONCERN:

This referral form is not for emergencies. If the member is experiencing an emergency or immediate safety concern, direct the member to 911 or the nearest emergency department. The CCH Maternal & Infant Health Program is a care coordination service. It does not provide clinical evaluations, diagnoses, or medical treatment.

Date of Referral: _____

MEMBER INFORMATION

Member Name: _____ Date of Birth: _____

Preferred Language: _____ CCH Member ID: _____

Mailing Address: _____ Phone: _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ Mail ☐ Other: _____

Best Time to Contact: _____

Alternate Contact Person & Phone Number: _____

PREGNANCY / POSTPARTUM INFORMATION

Current Status: ☐ Pregnant ☐ Postpartum ☐ Recent delivery ☐ Pregnancy status unknown

Estimated Delivery Date: _____ Delivery Date (if applicable): _____

Gestational Age (if known): _____ OB Provider: _____

REASON FOR REFERRAL (Check all that apply)

- | | | |
|---|---|--|
| ☐ Maternal mental health screening/support | ☐ Prenatal care gap | ☐ Health equity need |
| ☐ Positive maternal mental health screening | ☐ Postpartum care gap | ☐ Care coordination |
| ☐ Additional maternal mental health follow-up | ☐ Prenatal immunization gap | ☐ Complex care needs |
| ☐ Doula education/resource navigation | ☐ Member requesting CCH assistance | ☐ Difficulty accessing care |
| ☐ Social determinant of health/barrier to care | ☐ Community resource assistance | ☐ Other: _____ |

MATERNAL MENTAL HEALTH — IF APPLICABLE

Screening Date: _____ Screening completed? ☐ Yes ☐ No ☐ Unknown

Screening tool: ☐ PHQ-9 ☐ GAD-7 ☐ EPDS-10 ☐ EPDS-3 ☐ Other: _____

Follow-up needed? ☐ Yes ☐ No ☐ Unknown Was member referred to SimpleBehavioral: ☐ Yes ☐ No

Result/Clinical Concern: _____

REASON FOR REFERRAL

Please describe the member's current need, concern, barrier, or requested assistance:

REFERRAL SOURCE

Name of person submitting the referral: _____

Provider / Office Name / Address: _____

Provider's Phone: _____ Provider's Fax: _____

Provider's Email: _____ PCP Name: _____

Relationship to Member: _____

*** PLEASE ATTACH CLINICALS ***

REFERRAL SUBMISSION & CONTACT INFORMATION

CCH Quality Management – Maternal & Infant Health Outcomes Program

Email: CCHQualityManagement@communitymedical.org | Fax: 559-724-4251

CCH Customer Service:

Phone: 559-724-4995 | Toll Free: 1-844-516-0181 (Monday–Friday, 8:00 a.m.–5:00 p.m.)

Disclaimer: Referrals may be initiated by a provider or another individual involved in the member's care. Submission of this form does not guarantee enrollment into the program; however, CCH will contact the member to complete enrollment.

Clinical care decisions, screening, diagnosis, and treatment remain the responsibility of the treating practitioner.