Maternity Referrals

Maternity referrals can be worked in Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, and Pike counties.

1. Verify the patient’s Medicaid. If the patient does not have Medicaid, assist with the application process.
2. Follow-up to ensure patient has received Medicaid and continue to assist with this process until Medicaid is obtained.
3. All maternity referrals will need to have a Referral Form created in ACORN.
4. Mark Self/Family as the Referring Provider on the Referral Form.
5. Mark Maternity Case Management as the Reason for Referral.
6. If a patient has concerns about continuing the pregnancy, refer the patient to the yellow pages or a referral sheet with multiple resources including those for adoption and abortion. Do NOT give the patient a piece of paper with only the name and number to an abortion clinic. Please refer to the Plan First protocol, page 1 where the Title X regulations are outlined regarding this issue.
7. A psychosocial assessment and case plan are required on all maternity case management referrals.
8. Assess for tobacco usage. If patient is agreeable to assistance with smoking cessation provide a referral to the Alabama Quitline. Provide continuous encouragement and education on the importance of smoking cessation. If the patient is interested in smoking cessation medication, the Quitline can provide the paperwork necessary to be completed by the physician. Follow-up will be necessary to ensure the paperwork is completed and the medications are received.
9. Assist the patient in establishing a maternity care provider. The patient has the right to choose any doctor she prefers for her maternity care.
10. Assist patient in making the initial appointment with the chosen provider.
11. Remind patient of the initial appointment with the provider.
12. Follow-up with the provider to verify patient kept initial appointment and to determine the next appointment date.
13. Follow-up with patient to see if any questions or needs arose during the initial appointment that require follow-up.
14. Continue to follow patient throughout pregnancy encouraging prenatal appointment compliance.
15. Assist with any barriers to prenatal appointment compliance.
16. If patient entered care in time for the gestational diabetes test, encourage completion of testing and assess for results. If patient is found to have diabetes or gestational diabetes, refer to diabetic classes performed by a Certified Diabetes Educator (CDE).
17. Encourage a referral to childbirth classes and if patient agrees, provide the information for available childbirth/breastfeeding classes.
18. Provide education regarding early elective deliveries.
19. Provide education regarding breastfeeding.

20. Provide education regarding safe sleep practices. Always Back to Sleep!
21. Provide education and referral to the Gift of Life family programs (Montgomery county only).
22. Encourage patient to keep postpartum appointment including providing appointment reminders to help ensure completion of the postpartum appointment.
23. Encourage patient to choose a reliable birth control method.
24. Ensure patient is established with a PMP for the infant.
25. All services must be documented. All documentation must be completed in the progress notes.
26. Complete the Report to Referring Provider when pertinent information has been obtained. Select “SAVE” each time information is added. Only select “Send report” once the case is being closed.
27. Code time for patients under the age of 21 to service are 81 and time for patients 21 and older to service area 82.