MR #: _____

MATERNAL SUPPORT SERVICE CONTINUING PATIENT CARE FORM

Maternal Last Name First	Agency Name and Address **Crystal Home Healthcare MIHP** 15819 Schoolcraft Road Detroit, MI 48227 Phone: (313) 493-4900 Fax: (313) 493-4904
Address For Care City State Zip	Referral By: Referral Date: Reported By: Agency 1st Visit Date: Reported By:
Patient Address if not the same as above	
Home #: Cell #:	Medicaid: _____ ❍**Pending** HMO/Other: _____
Responsible relative or friend: Relationship Phone	Complete Birth Date _____/_____/_____ Marital Status ❍S ❍M ❍W ❍D

Report By Physician

Diagnoses: (List Primary First and Date of Onset)	EDC_____LMP_____G_____P_____A_____
Complications:	Brief Medical History
Treatment:	Home☐Office☐Clinic☐ECF☐

Medical Orders and Plan of Treatment

- ☐ Any family member or personal history of Diabetes
- ☐ Homeless or dangerous living home situation
- ☐ Negative or ambivalent feelings about the pregnancy
- ☐ Mother under the age of 18 **and** has no family support
- ☐ Need for assistance to care for herself and infant
- ☐ Mother with cognitive emotional or mental impairment (low-functioning mom)
- ☐ Need for transportation to keep medical appointments
- ☐ Nutritional problems
- ☐ Need for childbirth education classes
- ☐ Abuse of alcohol or drugs or smoking

Client Needs:

- ☐ WIC
- ☐ Breastfeeding
- ☐ Employment
- ☐ Housing
- ☐ Food
- ☐ GED
- ☐ Baby Items

MIHP Referrals are encouraged and give the presence of any of the condition existing which are likely to adversely affect the pregnancy.

Date _____ Physician Name _____

Physician Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

************This form can be faxed back to 313.493.4904************

CRYSTAL HOME HEALTHCARE FIELD STAFF USE ONLY				
TIME & DATE OF VISIT ATTEMPTS	Attempt 1 Date _____/_____/_____ Time_____am pm ❍Drive By ❍Call ❍Letter	Attempt 2 Date _____/_____/_____ Time_____am pm ❍Drive By ❍Call ❍Letter	Attempt 3 Date _____/_____/_____ Time_____am pm ❍Drive By ❍Call ❍Letter	RETURNED TO OFFICE DATE