Crystal Home HEALTHCARE
Maternal-Infant Health Program

MR #: _____

MATERNAL SUPPORT SERVICE CONTINUING PATIENT CARE FORM

Maternal Information: FULL NAME: _____ Date of birth: ____/____/_____ Due date/EDC: ____/____/____ LMP ____/____/_____	Agency Name and Address **Crystal Home Healthcare MIHP** 15819 Schoolcraft Road Detroit, MI 48227 Phone: (313) 493-4900 Fax: (313) 493-4904 Referral By: Referral Date: Reported By:
Address For Care: _____ Street Address Apt# _____ MI _____ City State Zip	*CRYSTAL HOME HEALTH ONLY STAFF ONLY:* Agency 1st Visit Date: Reported By: Medicaid #: _____ ○Pending HMO/Health Plan: _____
Home #: Cell #:	Emergency Contact Name: Relationship Phone
CRYSTAL HOME HEALTHCARE STAFF USE ONLY: *COMMENTS/INSTRUCTIONS FOR CARE*	

Report By Physician

Diagnoses: (List Primary First and Date of Onset) Complications/Treatment: Prenatal Care Provided by Physician ○Yes ○No	Brief Medical History Home Office Clinic

Plan of Treatment

○ 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/ determine referrals needed for:** ○ WIC ○ Breastfeeding ○ Substance Abuse ○ Housing ○ Food ○ Parenting Classes ○ Baby Items

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

Physician or Clinic Name: _____

Phone: _____ Fax: _____ NPI: _____

Address: _____ City _____ Michigan 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 Time_____am pm Date ____/____/_____ ○Drive By ○Call ○Letter	Attempt 2 Time_____am pm Date ____/____/_____ ○Drive By ○Call ○Letter	Attempt 3 Time_____am pm Date ____/____/_____ ○Drive By ○Call ○Letter	**RETURNED TO OFFICE DATE**
PLAN OF CARE VISITS	SW Anticipated Visits	RN Anticipated Visits	RD Anticipated Visits	**Case Mgr Initials**