



Ascension

Maternal Health Patient Navigation Program Referral Form

Referral Fax Number: 904-450-7961

Office Phone Number: 904-450-7960

All referrals ***must include:***

- Maternal Health Patient Navigation Referral Form (this packet)
- Patient's Demographic Form (Facesheet)
- Referral Order with reason for referral
- Completed Social Determinants of Health Screening
- Completed release of medical records
- OB Visit/History
- Maternal Health Telehealth Program and Use of Provided Monitoring Devices, if applicable and ordered by provider on Referral Order (attached with this document)

Program Overview:

The Ascension Maternal Health Patient Navigation Program is a patient-centered, relationship-based model of care designed to reduce barriers and improve outcomes for pregnant and postpartum individuals – particularly those with high social vulnerability or complex needs. Patient Navigators (social workers, community health workers, or nurses) provide individualized support from pregnancy through the postpartum period, ensuring timely, coordinated, and culturally sensitive care.

Referring Provider Information

Date: _____

Referring Provider Name: _____

Referring Provider Phone Number: _____

Office / Provider Contact Name & Phone Number: _____

Patient Information

Patient Name (Last, First): _____

Date of Birth: _____

Home Address: _____

Cell Phone Number: _____

Home Phone Number: _____

Best Time to Reach Patient: _____

Insurance policy name: _____

Insurance policy number: _____

Insurance policy group number: _____

Prenatal Care Information

Number of Prenatal Appointments Completed to Date: _____

Estimated Delivery Date: _____

Anticipated Delivery Hospital: _____

Is the patient considered late to prenatal care or as having gaps in prenatal care?

- Yes No Unknown

Medical Conditions

(Check all that apply)

- Hypertension (HTN) Diabetes Anemia Obesity Other:

Medical Device Request

- Blood Pressure Cuff Glucometer & Test Kit Digital Scale Anemia Test Kit

Other: _____

Additional Notes / Reason for Referral

Referral Submitted by:

Name: _____ Title / Role: _____

Organization: _____

Preferred Method for Program Follow-Up:

- Phone Fax Email Other: _____

Required Patient Referral Forms & Consents (attach completed forms) and fax to 904-450-7961:

- Maternal Health Patient Navigation Referral Form (this packet)
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Maternal Health Telehealth Program and Use of Provided Monitoring Devices

1. Use of Provided Monitoring Devices

I acknowledge that I have been issued the following monitoring devices for participation in the Maternal Telehealth Program. I understand and agree to the following:

- I acknowledge receipt of the following device(s):
 - Blood Pressure Monitor
 - Weight Scale
 - Glucometer
 - Other _____
- I understand that I am the only person authorized to use these devices. I will use them solely for monitoring my own health and will not permit others to use them. .

2. Purpose and Scope

- I understand that the use of these devices is part of my clinical care and is intended to assist my healthcare team in assessing and managing my health status. I acknowledge that these devices are not a substitute for in-person medical care.
- I agree to take and record readings as instructed by my healthcare team, either daily or at the frequency determined medically necessary.
- I understand that failure to take or record readings as directed may limit the effectiveness of the program.
- I will not tamper with or misuse the equipment and accept responsibility for any damage or loss.
- I agree to take readings as instructed, ideally daily or as medically necessary.
- I acknowledge that this program is not a 24/7 emergency monitoring service. For emergencies, I will call 911.

3. Withdrawal from Program

- I may withdraw from the program at any time by notifying my program coordinator. Upon withdrawal, I agree to return all program-issued devices in good working condition.

I have read and understood the above information and consent to participate in the Maternal Telehealth Program. I understand that this consent remains valid while I am in possession of the monitoring devices.

By signing this form, I acknowledge that I have read and understood the terms outlined above. I consent to participate in the Maternal Health Telehealth Program, and I have had the opportunity to ask questions. All questions have been answered to my satisfaction

Patient Name: _____

Patient Signature: _____ Date: _____ Time: _____ AM/PM

Device(s) Issued By (Staff Name & Initial): _____

Ascension Sacred Heart/Ascension St. Vincents

8/2025