

**HIGH-RISK PERINATAL PROGRAM - ORDER SHEET**

PLEASE PRINT AND FILL OUT THE FOLLOWING INFORMATION COMPLETELY. INCOMPLETE INFORMATION WILL CAUSE A DELAY IN THE PROCESSING OF YOUR ORDER. **\*\*PLEASE USE BLACK INK\*\***

Date of Request: \_\_\_\_\_ **Requestor's Phone #:** \_\_\_\_\_

Organization/Agency: \_\_\_\_\_

Complete Delivery Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Attention:** \_\_\_\_\_ Dept: \_\_\_\_\_

**PLEASE SPECIFY THE # OF UNITS NEEDED IN THE BLANK (1 UNIT = 100 COPIES)**

Request for Maternal Transport <b>6-HRPP-001</b>		Request for Neonatal Transport <b>6-HRPP-011</b>	
Request for Participation: Pg 1 <b>6-HRPP-002 (REVISED 2012)</b>		Request for Participation: Pg 2 <b>6-HRPP-003 (REVISED 2012)</b>	
Hospital Discharge Summary <b>6-HRPP-004 (REVISED 2012)</b>		Financial Worksheet & Questionnaire <b>6-HRPP-010 (REVISED 2012)</b>	
Community Nursing Form: Pg 1 <b>6-HRPP-007</b>		Community Nursing Form: Pg 2 <b>6-HRPP-006</b>	
CHN Family Service Plan: English <b>6-HRPP-009E</b>		CHN Family Service Plan: Spanish <b>6-HRPP-009S</b>	

**PLEASE SPECIFY THE # OF COPIES NEEDED IN THE BLANK (individual copies)**

Parent Brochure (REVISED 2012)		Parent Handbook (Limit 25 per order)	
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**Please e-mail order form to:**  
[Barbara.valenzuela@azdhs.gov](mailto:Barbara.valenzuela@azdhs.gov)

If unable to send via e-mail, please **Fax to:** (602) 364-1496 or  
**Mail to:** Office of Women's and Children's Health  
Attn: Hospital & Transport Program Manager  
150 North 18<sup>th</sup> Avenue, **Suite 320**, Phoenix, Arizona 85007-3242

**PLEASE ALLOW 2 WEEKS FOR PROCESSING & ORDERS TO REACH YOUR OFFICE**

_____ NICP Approval	_____ Date
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NOTE: Program Managers reserve the right to decrease order quantities requested as necessary.

Revised: 8/2014