HIGH RISK PERINATAL PROGRAM (HRPP)
MATERNAL TRANSPORT ENROLLMENT FORM

ARIZONA DEPARTMENT OF HEALTH SERVICES
Health and Wellness for all Arizonans

The State of Arizona established a High Risk Perinatal Program to provide a system of Transportation, Hospital, Medical, and Follow-up for high risk newborns whose parents reside in Arizona.

MOTHER'S DEMOGRAPHICS

First Name:*	MI:	Last Name:*

Alias/ Maiden Name:	DOB:* / /	Phone #:*

Address & City: *	Zip:*

Race:* ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Pacific Islander ☐Bi/Multi-Racial ☐Unknown

Ethnicity:* ☐Hispanic/Latino ☐Unknown ☐Not Hispanic/Latino

Tribal Affiliation:	Reservation:

TRANSPORT INFORMATION

Transport Date:* / /	Flight Number:*	Gestational Age:*

Authorizing MFM Specialist:*

MFM Fellow calling on behalf of authorizing MFM:
(fill in MFM above)

From Facility:*	To Facility:*

Transport Mode:* ☐Air – Rotor ☐ Air-Fixed Wing ☐Ground
☐ Ground 1 Company:____________________________ ☐ Ground 2 Company:_________________________________

Choose only the (1) most significant reason

Reason for Transport/Diagnosis:* ☐Fetal Indication ☐Maternal Medical Indication
☐Pre-eclampsia/HELLP/Eclampsia ☐Preterm Labor ☐PROM<37 weeks
☐Vaginal Bleeding/Abruption/Previa/Accreta ☐ Other: ____

This program also assists families, when needed, to cope with catastrophic costs related to emergency transports. I am requesting participation in the High Risk Perinatal Program for any necessary transport. I am requesting financial assistance, if needed, and I understand that the HRPP is the payer of last resort. I authorize the release of any necessary medical records, social and financial information held by any institution or individual that provided services to me to the Arizona Department of Health Services (ADHS) and to their contracted providers for provider quality management purposes. I agree to submit all necessary documents on behalf of myself for purposes of collection from third party payers and shall retain no insurance proceeds from claims intended as payment for services.

Patient /Responsible Party Signature ____ Date _____________

I certify that this participant meets the medical criteria of the HRPP: ____ Date_____________
Transport Team Signature

*** = Required Information**
WHITE COPY to TRANSPORT TEAM / YELLOW COPY to FAMILY