Georgia FIMR/HIV Initiative Referral

Mother's Name (First, MI, Last): _____

Mother's Date of Birth (mm/dd/yyyy): _____ EDC: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Best Phone(s): _____ Alternate Phone:_____

Birth Hospital: _____ Mother's Hospital ID #: _____

Prenatal Care Provider: _____

Baby's Name (First, MI, Last): _____

Baby's DOB (mm/dd/yyyy): _____ Gender: ☐ Male ☐ Female

Baby's Hospital ID#: _____

Family Aware of Referral? ☐ Yes ☐ No Okay to Contact? ☐ Yes ☐ No

Maternal Interview – Discussed? ☐ Accepted ☐ Denied

Comments/Other Information:

_____

_____

Referral Made By: _____ Date: _____

Signature: _____ Phone: _____

Email: _____ Organization: _____

Methods for Referral

Refer By Mail:

Georgia Department of Public Health
FIMR/HIV Initiative
P O Box 2107
Atlanta, G.A. 30303

Contact Information:

Maternal & Child Health at 404-657-2850

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