KY-Moms
Maternal Assistance Towards Recovery
(MATR)

KY-Moms MATR Regional Contact:

KY Moms MATR Referral Form

Date of Referral: _____

Referral Guidelines

1. Please complete and submit this form to refer a pregnant individual or an individual no more than 12 months postpartum, to the KY-Moms MATR regional contact.
2. The individual you refer will be contacted by a KY-Moms MATR Prevention Specialist or Case Manager within 48-hours of receipt of Referral form.
3. During the referral process please engage the individual in a discussion about KY Moms MATR services and the referral process. This will help the individual understand why they are being referred for KY Moms MATR services.
4. If possible, please attach a **signed Release of Information form**, any completed copies of a substance use screening/assessment tool, and a **medical proof of pregnancy or postpartum status if you are not the diagnosing provider**. This allows for coordination of services between providers, quicker engagement into services, and provides support of the client. Please do not include any behavioral or medical health information without the signed release of information, as required by HIPAA.

Demographic Information

Name: _____

Address: _____

_____

Preferred Contact Method: ☐**Email** ☐**Text** ☐**Phone**

Phone/Text Number: **#:** _____

Email: _____

Referral Information

Please identify patient's current status: ☐ Pregnant ☐ Postpartum Due/Delivery Date:_____

Pregnancy/Postpartum Diagnosis Code: _____ Substance Use Diagnosis Code: _____

If no diagnosis available, list specific concern/symptoms:_____

Medicaid #: _____ or Private Insurance #: _____

☐YES / ☐NO Does patient currently present with substance use RISK FACTORS during pregnancy or postpartum?

☐YES / ☐NO Does patient currently present with SUBSTANCE USE consequences during pregnancy or postpartum?

Referring Provider Name and Title (Printed): _____

Provider Signature: _____

☐ I am attesting that I have the ability to diagnose the patient and/or have permission to provide the patient's diagnosis as proof of pregnancy/postpartum period above on behalf of the referring medical provider.

Name of Referring Agency: _____

Phone number of Referring Agency: _____

Email Address of Referring Agency: _____

For KY-Moms MATR Use Only

Date Received: _____ Date Contacted: _____

Prevention Education Appointment: _____ Case Management Appointment: _____

Revised: 12.03.2024