

Medical University of South Carolina OPAC Referral Form
96 Jonathan Lucas St., Ste 312 P.O. Box 250607, Charleston, SC 29425
(843)792-9909 Office (843)792-5127 Fax

Date _____
 Child's Name _____ MRN _____
 DOB _____ Sex _____ Race _____

Mother's Name _____ MRN _____ DOB _____
 Address _____

County _____
 Telephone Number(s) (h) _____ (w) _____ (o) _____

Caregiver's Name _____
 Address _____

County _____
 Telephone Number(s) (h) _____ (w) _____ (o) _____

Placement Agency(DSS) _____
 Contact Person (case worker) _____

Primary Care MD (print) _____
 Address _____

Telephone Number _____
 First Visit Date _____

Place of Birth _____
 AZT Started Y N Dose _____
 6 wk Supply Dispensed Y N Method of Delivery _____
 Birth Weight _____ Apgars _____
 Gestational Age _____
 Referring Agency _____
 Contact Name _____ Number _____

Prenatal Hx (include Mom's Dx date, Tx during pregnancy & L&D, other pertinent psychosocial information):

OFFICE USE ONLY

Date Received _____ Appointment Given To _____
 Appointment Date _____ 1st Appt. letter mailed Y N