Department of Public Social Services

PREGNANCY VERIFICATION

PATIENT NAME:	DATE:	PLEASE RETURN COMPLETED FORM By:
CASE NUMBER:	ELIGIBILITY WORKER:	

TO BE COMPLETED BY EXAMINING PHYSICIAN

Please verify pregnancy for purposes of establishing eligibility and the effective date of the Pregnancy Special Need Payment. Please note that if the patient is pregnant, an estimated date of confinement (EDC) and the date of medical confirmation must be provided to establish eligibility to the Special Need.

PREGNANT: ☐ YES ☐ NO	EDC: (MUST BE PROVIDED)	DATE PREGNANCY CONFIRMED BY DOCTOR:

COMMENT:

PHYSICIAN SIGNATURE ▶	TELEPHONE:	DATE:
ADDRESS:		

DPSS 306 (Rev. 9/98) PREGNANCY VERIFICATION

RIVERSIDE COUNTY HEALTH SYSTEM
DIVISION OF AMBULATORY CARE

HEALTH CENTER: _____ DATE: _____

ADDRESS: _____

CITY, ZIP CODE: _____ PHONE: _____

PREGNANCY TEST RESULT FORM

TO WHOM IT MAY CONCERN:

This is to confirm that, _____ (NAME), _____ (LMP)

had a hCG-urine pregnancy test performed on _____ (DATE), which was found to be negative / positive. She would like to discuss the services available at your agency.

(SIGNED) _____ (RN)

PHONE _____

DOH-HPS-187 (Rev 12/12) DISTRIBUTION: ORIGINAL—Patient: COPY—Patient Record