

Doula Intake Form

Email completed forms and copies to DOULA@luminishealth.org

Today's Date ____/____/____

Doula Name _____

Home Address _____

City _____ State _____ Zip _____

Phone Number (____) _____ - _____ Email _____

Doula Agency (if applicable): _____

Name of Doula Training Program _____

**If not on the approved list, please provide a copy of your program's curriculum for review and approval.*

Medicaid program approved: **Yes / NO** If no are you interested in enrolling: Yes /No

View link for additional information: Pages - Medicaid Doula Program (maryland.gov)

What language(s) do you speak: _____

Please provide the following for each encounter: (send to DOULA@luminishealth.org)

- Doula Intake Form
- Copy of COVID Vaccination Card
- Signed Doula and Patient agreement

Client Information

Client Name _____

Client Date of Birth _____ Baby's Due Date _____

Phone number (____) _____ - _____

OB Provider/Practice Name: _____

Birth Plan:

For questions please contact:

1. Registration email DOULA@luminishealth.org
2. L&D unit call 443-481-6258 or email jandres@luminishealth.org