# 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_____

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**)

- o Doula Intake Form
- o 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 443-481-6281 or email jandres@luminishealth.org