

# Doula Intake Form

Email completed forms and copies to [DOULA@luminishealth.org](mailto: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](mailto:DOULA@luminishealth.org))

- Doula Intake Form
- 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](mailto:DOULA@luminishealth.org)
2. L&D unit call 443-481-6281 or email [jandres@luminishealth.org](mailto:jandres@luminishealth.org)