Notification of Pregnancy Form

***Required Field**

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to: 1-866-681-5125.**

MEMBER INFO

Member ID* DOB* (mmddyyyy)

Last Name* First Name*

Mailing Address

City State Zip

Home Phone – – Cell Phone – –

Email Address

Primary Insurance (for mom or baby) other than Medicaid? Yes No

Due Date* (mmddyyyy) Date of last Chlamydia Screening (mmddyyyy):

Date of first Prenatal Visit (mmddyyyy) Date of last Pap Smear (mmddyyyy):

Race/Ethnicity (Mark each box with a thick **X**)

White Black/African American Hispanic/Latina American Indian/Native American

Asian Hawaiian/Pacific Islander Other Please specify

Preferred Language (if other than English)

Number of Full Term Deliveries Number of Stillbirths

Number of Preterm Deliveries Enrolled in WIC? Yes No

Number of Miscarriages/Abortions Planning to breastfeed? Yes No

Height ' " Pre-Pregnancy Weight Pre-Pregnancy BMI

PREGNANCY RISK ASSESSMENT

Are any of the following risk factors present?* If there are no known risk factors, please fill in here

History (place a thick X for all that apply):

Previous Preterm (<37 weeks) delivery?

If yes, was the delivery spontaneous?

Currently on 17P?

Recent delivery (within past 12 months)?

(within past 6 months)?

Previous C-Section?

Previous severe preeclampsia?

Diabetes (prior to pregnancy)?

Sickle Cell?

Asthma?

Worse symptoms during pregnancy?

Current Pregnancy (place a thick X for all that apply):

Preterm labor this pregnancy?

Current placenta previa?

Vaginal bleeding after 14 weeks?

Shortened Cervix < 23 weeks this pregnancy?

Length

Current gestational diabetes?

Current preeclampsia?

Current oligohydramnios?

Twins? Triplets? Discordant?

Current fetal growth restriction?

Current congenital anomalies?

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Last Name*

First Name* DOB* (mmddyyyy)

History (place a thick X for all that apply):

High Blood Pressure (prior to pregnancy)? .....

Well controlled? .....

Previous neonatal death or stillborn?.....

Associated with maternal health condition?.....

HIV positive? HIV negative? Testing refused?

AIDS? .....

Seizure disorder? .....

Seizure within the last 6 months? .....

Previous alcohol or drug abuse? .....

Current Pregnancy (place a thick X for all that apply):

BMI <20 or poor weight gain this pregnancy? .....

UTI/Pyelo/Bacteriuria this pregnancy? .....

Current severe hyperemesis?.....

Current mental health concerns?.....

List

Current STD? List

Current tobacco use? Amount

Current alcohol use? Amount

Current street drug use?.....

Any social needs? Yes No Please list below.

Other Significant Risk Factors Yes No Please list below.

Date (mmddyyyy)

OB Provider Name*

TIN/ID Number* Phone Number – –

Mailing Address

City State Zip Code

If you would like your patient to receive a free 3 month supply of prenatal vitamins, please complete the Prenatal Vitamin Form. For any questions regarding this form or the Start Smart program, please call 1-800-783-5386.

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