



OBSTETRIC NOTIFICATION / RISK ASSESSMENT FORM

Please complete initial assessment at member's 1st prenatal visit or by the end of the first trimester, and/or when insurance coverage changes. When completed, submit via mail PreferredOne 127 Washington Ave, East Building, Fourth Floor, North Haven, CT 06473 or fax to 203-239-0016.

| PATIENT INFORMATION | | | | | | | | | | |
|---------------------|-----|------------------|--|------|--|--|---|-----|-----|---|
| Last Name | | | First Name | | | Member ID# | | | DOB | |
| Address | | | | City | | State | | ZIP | | |
| Phone | | Primary Language | | Race | | G | T | P | A | L |
| EDC | LMP | | Date of 1 st prenatal visit | | | Date of 1 st visit under plan | | | | |

| PROVIDER INFORMATION | | |
|-----------------------|--------------|---|
| Last Name | First Name | Plan Provider ID# |
| Office Phone | Office Fax | Contact Person |
| Hospital for delivery | Hospital ID# | Other Insurance: <input type="checkbox"/> YES <input type="checkbox"/> NO |

HIV Test/Info Offered: YES NO, Reason: _____ Pt Declined Will offer at a future appt.
WIC Referral Made: YES NO, Reason: _____ Pt Declined Will offer at a future appt.

| Please identify all risks that apply to pregnancy or patient history: | Circle if Yes or No | | | |
|--|-----------------------|---|---------|---|
| | Early Risk Assessment | | History | |
| RISK FACTORS (To Be Completed by Clinician) | | | | |
| I. Demographic & Psycho/Social | | | | |
| - Age extreme <18 or >35 | Y | N | | |
| - Depression / Psychosocial disorder | Y | N | Y | N |
| - Obesity | Y | N | Y | N |
| - Smoker | Y | N | Y | N |
| - Substance Abuse (Alcohol / Drugs) | Y | N | Y | N |
| - Transportation Issues | Y | N | Y | N |
| - Trauma / Violence/ Homeless | Y | N | Y | N |
| II. OB/Gynecological | | | | |
| - Hyperemesis (Severe vomiting, weight loss, ketosis etc.) | Y | N | Y | N |
| - Cervix Incompetent / Short (<2.5cm) / Cerclage | Y | N | Y | N |
| - Multiple Gestation 2, 3, 4, 5 or other | Y | N | Y | N |
| - Fetal Reduction | Y | N | Y | N |
| - Preterm Labor | Y | N | Y | N |
| - Preterm Birth | Y | N | Y | N |
| - Gestational Diabetes/ Diabetes Mellitus | Y | N | Y | N |
| - Pre-eclampsia/Eclampsia, Pregnancy Induced Hypertension, Chronic Hypertension | Y | N | Y | N |
| - Previous poor pregnancy outcome (i.e., LBW, Fetal Death, Placenta Previa, NICU stay &/or other serious risk) | | | Y | N |
| III. Other Identified Risks, including medical conditions, NOT LISTED ABOVE (Describe here): | | | | |
| IV. Prescription Medications: | | | | |
| V. Please check here if you wish a Case Manager to contact you about this patient. <input type="checkbox"/> | | | | |

Clinician's Signature _____ Date: _____

Confidentiality Note: The documents accompanying this facsimile transmission may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by telephone or by return FAX and destroy this transmission, along with any attachments. Thank you.