

Phone # 800-351-8777
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P.O. Box 31401
Tampa, Fl. 33631-3401

PRENATAL NOTIFICATION FORM

Member Name _____ OB Provider _____
Member Phone # _____ OB Provider Phone _____
Member I.D. # _____ OB Provider Fax _____
Member DOB _____ OB Tax ID # _____
EDC _____ LMP _____ GRAVIDA _____ PARA _____ TERM _____ PRE-TERM _____ AB _____ L _____
Initial Prenatal Visit Date _____ Primary Language Spoken _____

Current Pregnancy Risks

(please check if "yes")

- | | |
|--|---|
| <input type="checkbox"/> Preterm Labor | <input type="checkbox"/> Psychiatric/emotional disorder
specify: _____ |
| <input type="checkbox"/> Incompetent Cervix | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Twins <input type="checkbox"/> Triplets | <input type="checkbox"/> Other Social Challenges specify _____ |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> I.U.G.R. |
| <input type="checkbox"/> Placenta previa or vaginal bleeding | <input type="checkbox"/> Substance Abuse specify _____ |
| <input type="checkbox"/> Preeclampsia or P.I.H. | <input type="checkbox"/> Tobacco Use specify _____ |
| <input type="checkbox"/> Under age 16 | <input type="checkbox"/> Alcohol Use specify _____ |
| <input type="checkbox"/> Over age 35 | <input type="checkbox"/> Nutritional Deficit specify _____ |
| <input type="checkbox"/> Fetal anomaly specify _____ | <input type="checkbox"/> Other Risk specify _____ |

Previous Pregnancies

(please check if "yes")

- | | |
|--|--|
| <input type="checkbox"/> Preterm Labor # weeks _____ | <input type="checkbox"/> Previous low birthweight weight _____ |
| <input type="checkbox"/> Preterm delivery # weeks _____ | <input type="checkbox"/> Congenital anomaly specify _____ |
| <input type="checkbox"/> PROM or PPRM # weeks _____ | <input type="checkbox"/> Placenta previa <input type="checkbox"/> abruptio |
| <input type="checkbox"/> Incompetent cervix | <input type="checkbox"/> Preclampsia <input type="checkbox"/> P.I.H. |
| <input type="checkbox"/> Spont. AB or Fetal demise # weeks _____ | <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Previous C-Section Reason _____ | <input type="checkbox"/> Other _____ |

Current Medical Conditions

(please check if "yes")

- | | |
|--|---|
| <input type="checkbox"/> H.I.V. or A.I.D.S. _____ | <input type="checkbox"/> STD _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Mental/Emotional Illness _____ |
| <input type="checkbox"/> Substance abuse rehab _____ | <input type="checkbox"/> Cardiac Condition _____ |
| <input type="checkbox"/> Chronic hypertension _____ | <input type="checkbox"/> Neurological condition _____ |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin dependent | <input type="checkbox"/> Other _____ |

Health Screening

Current Medications _____ Domestic Violence screening? _____
HIV Tested? _____ Test declined? _____

Date: _____

Completed by: _____

Note to OB Provider: This form generates a Comprehensive Prenatal Authorization. It should be submitted to WellCare **within 30 days of the initial prenatal visit to expedite case management, the claims process and ensure timely reimbursement.