

# 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 1-877-647-7475.**

## Member's Current Contact Information

\*Member ID:

DOB (mmddyyyy):

Last Name:

First Name:

Mailing Address:

City:

State:

Zip Code:

Home Number:

Cell Number:

Email Address:

## OB Provider Information

\*OB Provider Name:

\*OB Provider TIN/ID #:

OB Provider Mailing Address:

OB Provider City:

OB Provider State:

OB Provider Zip Code:

OB Provider Phone Number:

Today's Date (mmddyyyy):

## General Information

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

\*Due Date (mmddyyyy):

Date of first prenatal visit (mmddyyyy):

Date of last Pap Smear (mmddyyyy):

Date of last Chlamydia Screening (mmddyyyy):

Race/Ethnicity (check all that apply):

Caucasian, Non-Hispanic/Latina

Black/African American

Hispanic/Latina

American Indian/Native American

Asian

Hawaiian/Pacific Islander

Other ethnicity (please specify):

If other ethnicity, please specify.

Preferred Language (if other than English):

Number of Full Term Deliveries:

Number of Preterm Deliveries:

Number of Miscarriages/Abortions:

Number of Stillbirths:

Any social needs?    Yes    No

If yes, please specify social needs:

Enrolled in WIC?    Yes    No    Planning to Breastfeed?    Yes    No    Height:

(Feet, Inches)

Pre-Pregnancy Weight:

Pre-Pregnancy BMI:

Age less than 16?    Yes    No    Age greater than 40?    Yes    No

\*Are there any known pregnancy risk factors?    Yes    No

**\*Member ID:**

DOB (mmddyyyy):

Last Name:

First Name:

**History**

Previous Preterm delivery (<37 weeks)?      Yes      No      If yes, was the delivery spontaneous?      Yes      No

Currently on 17P?      Yes      No

Recent delivery (within past 12 months)?      Yes      No      Recent delivery (within past 6 months)?      Yes      No

Previous C-Section?      Yes      No      Previous severe preeclampsia?      Yes      No

Diabetes (prior to pregnancy)?      Yes      No      Sickle Cell?      Yes      No

Asthma?      Yes      No      If yes, are asthma symptoms worse during pregnancy?      Yes      No

High Blood Pressure (prior to pregnancy)?      Yes      No      If yes, is high blood pressure well controlled?      Yes      No

Previous neonatal death or stillborn?      Yes      No

If yes, was neonatal death associated with an underlying maternal health condition?      Yes      No

HIV Positive?      Yes      No      HIV Negative?      Yes      No      HIV Test Refused?      Yes      No      AIDS?      Yes      No

Seizure disorder?      Yes      No      If yes, has there been a seizure within the last 6 months?      Yes      No

**Current Pregnancy**

Preterm labor this pregnancy?      Yes      No      Current placenta previa?      Yes      No

Vaginal bleeding after 14 weeks?      Yes      No

Shortened Cervix <23 weeks this pregnancy?      Yes      No      If yes, Length \_\_\_ cm.

Current gestational diabetes?      Yes      No      Current preeclampsia?      Yes      No      Current oligohydramnios?      Yes      No

Current Twins?      Yes      No      Current Triplets?      Yes      No      Discordant growth?      Yes      No

Current fetal growth restriction?      Yes      No      Current congenital anomalies?      Yes      No

BMI < 20 or poor weight gain during this pregnancy?      Yes      No      UTI/Pyelo Bacteriuria this pregnancy?      Yes      No

Current severe hyperemesis?      Yes      No

Current mental health concerns?      Yes      No

If yes, please specify mental health concerns.

Current STD?      Yes      No      If yes, please list STD's.

Current tobacco use?      Yes      No      If yes, please specify amount used.

Current alcohol use?      Yes      No      If yes, please specify amount used.

Current street drug use?      Yes      No      If yes, please specify amount used.

Are there any other significant risk factors?      Yes      No

If yes, Please list other risk factors: