Kentucky Medicaid

Prenatal Notification Form

Fax 1-877-338-3659 | Web Address: www.kentucky.wellcare.com

MEMBER INFORMATION					
Last Name:		First Name, Middle Initial:		Date of Birth:	
Phone:		WellCare ID Number:		Primary Language:	

PROVIDER INFORMATION					
Type:	OB/GYN	Maternal Fetal Medicine	Primary Care Physician	Certified Midwife	
Last Name:		First Name:		Office Contact:	
WellCare ID Number:		NPI Number:		Participating:	Yes / No
Transfer of Care:	Yes / No	Phone:		Fax:	

PREGNANCY INFORMATION													
LMP		EDC		Gravida		Para		Full-term		Pre-term		AB		Live	

Date of First Visit:		Pregnancy Risk Level: Routine / High Risk +

PRE-EXISTING MEDICAL CONDITION (Please check if "Yes")		
Asthma	Diabetes	Periodontal Disease
Cancer	Drug/Alcohol/Tobacco Use	Renal Disease
Chromosomal or Genetic Disorder	Heart Disease	Sexually Transmitted Disease
Chronic Hypertension	HIV or AIDS	Sickle Cell Disease or Trait
Deep Vein Thrombosis	Neurological Disorder	Obesity
Thalassemia	Thyroid Disorder	Other

SOCIAL RISK FACTORS (Please check if "Yes")			
Emotional, Physical or Sexual Abuse	Homelessness	Lack of Transportation	*Language or Communication Barriers

*Language Translation and TTY services are available.
Please call Provider Services at 1-877-389-9457, Monday through Friday, between 8 a.m. and 6 p.m.

C	P	PREGNANCY RISKS (Please indicate if current "C" or previous "P")	C	P	
		Abruptio Placenta; number of weeks			Oligohydramnios
		Advanced Maternal Age			Placenta Previa
		Eclampsia/Pre-Eclampsia			Polyhydramnios
		Fetal Anomaly			Pregnancy Induced Hypertension
		Fetal Arrhythmia or Bradycardia			Post-term Pregnancy
		Fetal Demise			PROM or PPROM
		Gestational Diabetes: Insulin Dependent			Preterm Delivery; number of weeks
		Hyperemesis Gravidarum			Preterm Labor
		Incompetent Cervix			Previous Cesarean Section
		IUGR EFW or percentile			Spontaneous AB; how many
		Isoimmunization			Teen Pregnancy; age 17 and younger
		Low Birth Weight Infant			Twin-Twin Transfusion Syndrome
		Multiple Gestation Twins Triplets			Uterine Anomaly
		Nutritional Deficit			Other Complication

HEALTH SCREENING	
Domestic Violence Screening: Yes No	WIC Referral Given: Yes No
HIV Test Performed: Yes No	HIV Test Declined: Yes No
Post-Partum Depression or Other: Yes No	Mental Health Screening: Yes No

Current Medications:	Form Completed By:	Date:

**Note to OB Provider: This form generates a pregnancy notification and should be submitted to WellCare within thirty (30) days of the initial prenatal visit to expedite the member's placement into WellCare's Prenatal and/or High Risk Program. (Effective 11/01/2011) (Revised February 2015)

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