

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 1-844-816-6047.**

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:

