

# Notification of Pregnancy Form



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: 1-866-681-5125.**

## MEMBER INFO

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Member ID \_\_\_\_\_  
 DOB \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Primary Insurance (for mom or baby) other than Medicaid?

**Due Date** \_\_\_\_\_ Date of first Prenatal Visit: \_\_\_\_\_  
 Date of last Pap Smear: \_\_\_\_\_ Date of last Chlamydia Screening: \_\_\_\_\_  
 Race/Ethnicity (circle all that apply) White Black/African American Hispanic/Latina American Indian/Native American  
 Asian Hawaiian/Pacific Islander Other \_\_\_\_\_

Preferred Language (if other than English) \_\_\_\_\_  
 Number of Full Term Deliveries \_\_\_\_\_ Any social needs?  Height \_\_\_\_\_  
 Number of Preterm Deliveries \_\_\_\_\_ List \_\_\_\_\_ Pre-Pregnancy Weight \_\_\_\_\_  
 Number of Miscarriages/Abortions \_\_\_\_\_ Enrolled in WIC?   
 Number of Stillbirths \_\_\_\_\_ Planning to breastfeed?  Pre-Pregnancy BMI (if known) \_\_\_\_\_

## Pregnancy risk assessment

Are any of the following risk factors present? **If there are no known risk factors, please check here**

### History (check all that apply):

- Previous Preterm (<37 weeks) delivery?.....
- If yes, was the delivery spontaneous?.....
- Currently on 17P?.....
- Recent delivery (within past 12 months)?.....
- (within past 6 months)?.....
- Previous C-Section?.....
- Previous severe preeclampsia?.....
- Diabetes (prior to pregnancy)?.....
- Sickle Cell?.....
- Asthma?.....
- Worse symptoms during pregnancy?.....
- High Blood Pressure (prior to pregnancy)?.....
- Well controlled?.....
- Previous neonatal death or stillborn?.....
- Associated with maternal health condition?.....
- HIV positive?  HIV negative?  Testing refused?
- AIDS?.....
- Seizure disorder?.....
- Seizure within the last 6 months?.....
- Previous alcohol or drug abuse?.....

### Current Pregnancy (check all that apply):

- Preterm labor this pregnancy?.....
- Current placenta previa?.....
- Vaginal bleeding after 14 weeks?.....
- Shortened Cervix < 23 weeks this pregnancy?.....
- Length \_\_\_\_\_
- Current gestational diabetes?.....
- Current preeclampsia?.....
- Current oligohydramnios?.....
- Twins?  Triplets?  Discordant?
- Current fetal growth restriction?.....
- Current congenital anomalies?.....
- BMI <20 or poor weight gain this pregnancy?.....
- UTI/Pyelo/Bacteriuria this pregnancy?.....
- Current severe hyperemesis?.....
- Current mental health concerns?.....
- List \_\_\_\_\_
- Current STD? List \_\_\_\_\_
- Current tobacco use? Amount \_\_\_\_\_
- Current alcohol use? Amount \_\_\_\_\_
- Current street drug use?.....

Other Significant Risk Factors \_\_\_\_\_

If you would like your patient to receive a free 3 month supply of prenatal vitamins, please complete the Prenatal Vitamin Form. For any questions regarding this form or the Start Smart program, please call 1-866-895-1786.

Date _____	
OB Provider Name _____	TIN/ID Number: _____
Mailing Address _____	Phone Number _____
City _____	State _____ Zip Code _____