

Notification of Pregnancy Form



The earliest possible completion of this form allows the Start Smart for your Baby® program 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: 866-681-5125.**

Member Info

First Name _____ Last Name _____ Member ID# _____
 DOB _____ Mailing Address _____
 Home Phone # _____ City _____ State _____ Zip _____
 Cell Phone # _____ Email Address _____
 Other insurance _____ ID# _____ Policy Holder _____
 Date of 1st visit _____ EDC _____ Delivery Hospital _____
 Gravida _____ Para _____ Planning to breastfeed? Yes No
 SAB _____ EAB _____ HIV tested? Yes No Refused? Yes No
 Mother enrolled in WIC? Yes No Pediatrician chosen? Yes No Name _____

Pregnancy risk assessment (mark all that apply)

- Previous Preterm Delivery (<37 weeks)
 - Previous second trimester loss (14-24 weeks) or Stillborn/week _____
 - Previous Cesarean Section
 - Personal history of clotting disorder or family history of thrombotic event
 - Mental illness
 - Domestic Violence (history or current)
 - Smoker
 - Alcohol abuse
 - Drug abuse
 - 35 years or older
 - Other significant risk factor _____
 - No known risk factors
- Preexisting Medical Condition**
- Diabetes
 - Hypertension
 - Asthma
 - Sickle cell
- Current pregnancy**
- Gestational diabetes
 - Sexually transmitted disease
 - Preterm labor or incompetent cervix
 - IUGR
 - Oligohydramnios
 - Preeclampsia
 - Placenta previa
 - Multiple gestation

Please complete if you would like your patient to receive a free three (3) month's supply of prenatal vitamins. They will be shipped to (please choose) Provider Office Member [Please make sure accurate mailing address is on this form.]

Provider Info

Name _____
 Provider T.I.N. or N.P.I.# _____
 Phone # _____
 Fax # _____
 Mailing Address _____
 City _____ State _____ Zip _____

For any questions regarding this form or the Start Smart program please call 866-895-1786 (TDD/TTY 1-866-614-1949).

Name _____ Date _____
 Date of Birth _____

**Prenatal Plus
 Disp: #100
 No refills**

 Physician signature / Dispense as written

DEA# _____

Prescription is void if more than one (1) prescription is written per blank.

Completed by _____ Date _____ For Health Plan Use Only