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 1-866-681-5125.**

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: