Notification of Pregnancy Form

nh healthy families

Start Smart for Your Baby®

***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 INFO

Member ID*

DOB* (mmddyyyy)

Last Name*

First Name*

Mailing Address

City

State

Zip

Home Phone

Cell Phone

Email Address

Primary Insurance (for mom or baby) other than Medicaid? Yes ☐ No ☐

Due Date* (mmddyyyy)

Date of last Chlamydia Screening (mmddyyyy):

Date of first Prenatal Visit (mmddyyyy)

Date of last Pap Smear (mmddyyyy):

Race/Ethnicity (Mark each box with a thick **X**)

White ☐ Black/African American ☐ Hispanic/Latina ☐ American Indian/Native American ☐

Asian ☐ Hawaiian/Pacific Islander ☐ Other ☐ Please specify

Preferred Language (if other than English)

Number of Full Term Deliveries

Number of Stillbirths

Number of Preterm Deliveries

Enrolled in WIC? Yes ☐ No ☐

Number of Miscarriages/Abortions

Planning to breastfeed? Yes ☐ No ☐

Height

Pre-Pregnancy Weight

Pre-Pregnancy BMI

PREGNANCY RISK ASSESSMENT

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

History (place a thick X for 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? ..... ☐

Current Pregnancy (place a thick X for 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? ..... ☐

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Last Name*

First Name* DOB* (mmddyyyy)

History (place a thick X for all that apply):

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 (place a thick X for all that apply):

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? ..... ☐

Any social needs? Yes ☐ No ☐ Please list below.

Other Significant Risk Factors Yes ☐ No ☐ Please list below.

Date (mmddyyyy)

OB Provider Name*

TIN/ID Number* Phone Number

Mailing Address

City State Zip Code

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 1-866-769-3085.