

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 N	umber:			
Email Address:					
OB Provider Information					
*OB Provider Name:					
*OB Provider TIN/ID #:					
OB Provider Mailing Address:					
OB Provider City:		OB Provider State:	OB Pro	ovider Zip Co	de:
OB Provider Phone Number:		Today's Date (mmdd	іуууу):		
General Information					
Primary insurance (for mom or baby) other than Medicaid?	Yes	No			
*Due Date (mmddyyyy):	Date	of first prenatal visit (m	mddyyyy):		
Date of last Pap Smear (mmddyyyy):	Date	e of last Chlamydia Scree	ening (mmddy	ууу):	
Race/Ethnicity (check all that apply): Caucasian, No	n-Hispanic/La	itina Black/Afric	an American	Hispa	inic/Latina
American Indian/Native American Asia	n	Hawaiian/Pacific Islande	er	Other ethnic	ity (please specify):
If other ethnicity, please specify.					
Preferred Language (if other than English):					
Number of Full Term Deliveries: Number of Pi	reterm Deliver	ies:			
Number of Miscarriages/Abortions: Number	er of Stillbirths				
Any social needs? Yes No					
If yes, please specify social needs:					
Enrolled in WIC? Yes No Planning to Breastf	feed? Yes	No Height:			
Pre-Pregnancy Weight: Pre-Pregnancy BMI	:	((Feet, Inches)		
Age less than 16? Yes No Age greater than	n 40? Ye	es No			
*Are there any known pregnancy risk factors? Yes © 2021 Children's Medical Services Health Plan. All rights reserved.	No				Rev. 09 29 2021 FL-CMS-PN0P-2010

*Member ID: DOB (mmddyyyy):
Last 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
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
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?YesNoCurrent preeclampsia?YesNoCurrent oligohydramnios?YesNo
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: