## 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 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 Medicai	d? Yes No
Due Date* (mmddyyyy)	Date of last Chlamydia Screening
Date of first Prenatal Visit (mmddyyyy)	(mmddyyyy): Date of last Pap Smear
Race/Ethnicity (Mark each box with a thick <b>X</b> )	(mmddyyyy):
White Black/African American Hispanic/Latin	na 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?* I	if there are no known risk factors, please fill in here
	Current Pregnancy (place a thick X for all that apply):
Previous Preterm (<37 weeks) delivery?	Preterm labor this pregnancy?
If yes, was the delivery spontaneous?	Current placenta previa?
Currently on 17P?	Vaginal bleeding after 14 weeks?
Recent delivery (within past 12 months)?	Shortened Cervix < 23 weeks this pregnancy?
(within past 6 months)?	Length
Previous C-Section?	Current gestational diabetes?
Previous severe preeclampsia?	Current preeclampsia?
Diabetes (prior to pregnancy)?	Current oligohydramnios?
Sickle Cell?	Twins? Triplets? Discordant?
Asthma?	Current fetal growth restriction?
Worse symptoms during pregnancy?	Current congenital anomalies?

## Notification of Pregnancy Form

Last Name*		
First Name*	DOB* (mmddyyyy)	
History (place a thick X for all that apply):	Current Pregnancy (place a thick X for all that apply):	
High Blood Pressure (prior to pregnancy)?	BMI <20 or poor weight gain this pregnancy?	
Well controlled?	UTI/Pyelo/Bacteriuria this pregnancy?	
Previous neonatal death or stillborn?	Current severe hyperemesis?	
Associated with maternal health condition?	Current mental health concerns?	
HIV positive? HIV negative? Testing refused?	List	
AIDS?	Current STD? List	
Seizure disorder?	Current tobacco use? Amount	
Seizure within the last 6 months?	Current alcohol use? Amount	
Previous alcohol or drug abuse?	Current street drug use?	
Other Significant Risk Factors Yes No Please list below.		
Date (mmddyyyy)  OB Provider Name*		
TIN/ID Number* Phone Numl		
Mailing Address		
	tate 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 1-866-796-0530.

