Notification of Pregnancy Form

The earliest possible completion of this form allows us to best use coordinate care for your patient to achieve a healthy pregnancy. **Please fax form to 888-656-7541.**

***Required field**

Member Contact Information

Member ID _____
DOB (mmddyyyy)_____
Last Name _____ First Name _____
Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email Address _____

OB Provider Information

OB Provider Name _____
OB Provider TIN/ID #_____
OB Provider Mailing Address _____
OB Provider City _____ State _____ Zip _____
OB Provider Phone _____
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/Lanina
- ☐ Black/African American
- ☐ Hispanic/Latina
- ☐ American Indian/Native American
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ Other ethnicity (please specify) _____

Preferred Language _____
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_____
Enrolled in WIC? Yes _____ No ____
Planning to Breastfeed? Yes _____ No ____
Height _____ 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 ___
If yes, please specify _____

History
Previous preterm delivery (<37 weeks)? Yes___ No____
If yes, was the delivery spontaneous? Yes____ No____
Currently on 17P? Yes____ No____
Recent delivery (within the past 12 months)? Yes___ No____
Recent delivery (within the 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 symptoms worse during pregnancy? Yes____ No____
High Blood Pressure? 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/Pylo? 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/SDI? Yes____ No____ If yes, please specify_____
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: _____