

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: 1-844-931-1229.**

MEMBER INFO

Member ID*	<input type="text"/>	DOB* (mmddyyyy)	<input type="text"/>
Last Name*	<input type="text"/>	First Name*	<input type="text"/>
Mailing Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
Home Phone	<input type="text"/> - <input type="text"/> - <input type="text"/>	Cell Phone	<input type="text"/> - <input type="text"/> - <input type="text"/>
Email Address	<input type="text"/>		
Primary Insurance (for mom or baby) other than Medicaid?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Due Date* (mmddyyyy)	<input type="text"/>	Date of last Chlamydia Screening (mmddyyyy):	<input type="text"/>
Date of first Prenatal Visit (mmddyyyy)	<input type="text"/>	Date of last Pap Smear (mmddyyyy):	<input type="text"/>
Race/Ethnicity (Mark each box with a thick X)			
White <input type="checkbox"/>	Black/African American <input type="checkbox"/>	Hispanic/Latina <input type="checkbox"/>	American Indian/Native American <input type="checkbox"/>
Asian <input type="checkbox"/>	Hawaiian/Pacific Islander <input type="checkbox"/>	Other <input type="checkbox"/>	Please specify <input type="text"/>
Preferred Language (if other than English)	<input type="text"/>		
Number of Full Term Deliveries	<input type="text"/>	Number of Stillbirths	<input type="text"/>
Number of Preterm Deliveries	<input type="text"/>	Enrolled in WIC?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Miscarriages/Abortions	<input type="text"/>	Planning to breastfeed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Height <input type="text"/> ' <input type="text"/> "	Pre-Pregnancy Weight <input type="text"/>	Pre-Pregnancy BMI	<input type="text"/>

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?	<input type="checkbox"/>
If yes, was the delivery spontaneous?	<input type="checkbox"/>
Currently on 17P?	<input type="checkbox"/>
Recent delivery (within past 12 months)?	<input type="checkbox"/>
(within past 6 months)?	<input type="checkbox"/>
Previous C-Section?	<input type="checkbox"/>
Previous severe preeclampsia?	<input type="checkbox"/>
Diabetes (prior to pregnancy)?	<input type="checkbox"/>
Sickle Cell?	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>
Worse symptoms during pregnancy?	<input type="checkbox"/>

Current Pregnancy (place a thick X for all that apply):

Preterm labor this pregnancy?	<input type="checkbox"/>
Current placenta previa?	<input type="checkbox"/>
Vaginal bleeding after 14 weeks?	<input type="checkbox"/>
Shortened Cervix < 23 weeks this pregnancy?	<input type="checkbox"/>
Length <input type="text"/>	<input type="text"/>
Current gestational diabetes?	<input type="checkbox"/>
Current preeclampsia?	<input type="checkbox"/>
Current oligohydramnios?	<input type="checkbox"/>
Twins? <input type="checkbox"/> Triplets? <input type="checkbox"/> Discordant? <input type="checkbox"/>	
Current fetal growth restriction?	<input type="checkbox"/>
Current congenital anomalies?	<input type="checkbox"/>



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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

For any questions regarding this form or the Start Smart program, please call 1-844-289-2264.

