Notification of Pregnancy

Date of service: _____

Member name:

Member address:

Member telephone:

DOB (MM/DD/YYYY):
_____ **Age:**_____ **yrs**

Taking prenatal vitamins? □ Yes □ No

Member RID:

Physician name:

Physician telephone:

NPI/LPI:

Pre-pregnancy weight (lbs)	**Current weight (lbs)**

BMI > 30 □ Yes □ No
BMI < 19 □ Yes □ No

Height
_____ ft _____ in

Toxicology ordered? □ Yes □ No

Delivery system:
□ MDwise □ MHS □ Anthem

Race:
□ White □ Black □ Am Indian □ Asian
□ Other _____

Ethnicity:
□ Hispanic □ Non-Hispanic

Primary language:
□ English □ Spanish □ Other_____

First prenatal visit (MM/DD/YYYY): _____

LMP (MM/DD/YYYY): _____
 # weeks pregnant _____

1. Maternal Obstetrical History

Check all that apply:

□ Preterm labor	□ Hx	□ Current
□ Tocolytics used	□ Hx	□ Current
@ ____ weeks' gestation		
□ PROM	□ Hx	□ Current
□ Gestational diabetes	□ Hx	□ Current
□ Preg – Ind HTN	□ Hx	□ Current
□ Placenta previa	□ Hx	□ Current
□ Placenta abruption	□ Hx	□ Current
□ Multiple gestation	□ Hx	□ Current
□ Pre-eclampsia	□ Hx	□ Current
□ Eclampsia	□ Hx	□ Current
□ Incompetent cervix	□ Hx	□ Current
□ Cerclage placement	□ Hx	□ Current
□ Cervix dilation > 2 cm < 35 wks	□ Hx	□ Current
□ Lack of maternal weight gain	□ Hx	□ Current
□ SABS/TABS	□ < 3x	□ ≥ 3x

□ Hx of cone biopsy
□ Reduction w/ or w/o complications
□ Current hypermesis < 10 lbs wt loss
□ Current hypermesis > 10 lbs wt loss
□ Vaginal bleeding > 2 episodes
□ Prior C-Section
□ Rh negative
□ Previous fetal/neonatal demise
□ **If none of the above apply, please check here.**
< 12 months between births □ Yes □ No

2. Previous Infant/Findings

□ Stillbirth >28 wks
□ Preterm birth < 30 wks
□ Preterm birth 30-36 wks
□ Birth weight < 2500 gms
□ Birth weight > 4000 gms

9. Diagnosis of Pregnancy Risk

□ V22 – Normal pregnancy
□ V23 – High-risk pregnancy
□ Gravida _____
□ Para _____

List any other medical/psychological problems not included above or other issues which may place the member at risk: _____
_____
_____
_____

3. Maternal Medical History

Check all that apply:	**Controlled?**		**On meds?**	
□ Thyroid condition	□ Yes	□ No	□ Yes	□ No
□ Cardiac condition	□ Yes	□ No	□ Yes	□ No
□ Hypertension	□ Yes	□ No	□ Yes	□ No
List blood pressure _____/_____				
□ Seizure disorder	□ Yes	□ No	□ Yes	□ No
□ DM (I or II)	□ Yes	□ No	□ Yes	□ No
Hemoglobin A1c	□ ≥ 9		□ ≤ 9	
□ Asthma/COPD	□ Yes	□ No	□ Yes	□ No
Rescue inhaler	□ < 3x/mo		□ > 3x/mo	
□ Sickle cell anemia	Recent crisis?		□ Yes	□ No
□ Cancer	□ Hx		□ Current	
□ Pylonephritis	□ Hx		□ Current	
□ STIs	□ Hx		□ Current	
□ Chronic UTIs	□ Hx		□ Current	
□ Eating disorder	□ Hx		□ Current	

□ Hx of gastric bypass
□ Systemic lupus
□ Prior exposure to teratogenic substances
□ Anemia
□ Current DVT/pulmonary embolism
□ Other coagulation disorder
□ Auto-immune disorder
□ Current uterine anomalies/fibroids
□ Renal condition
□ Periodontal/dental problems
□ Hepatitis B or C
□ History of transplant
□ **If none of the above apply, please check here.**
HIV/AIDS tested □ Yes □ No
ER or hospitalization in last 6 mos. □ Yes □ No
If yes, how many times?_____

4. List All Current Medications

□ **None**
□ **Other** _____
_____
_____

10. Referrals

□ Indiana Family Helpline – **1-800-433-0746**
□ Tobacco Quit Line – **1-800-QUIT-NOW**
□ WIC (breastfeeding classes, formula, social services, nutrition/foods)
□ Childbirth/parenting classes
□ Domestic violence referral
□ Mental health/substance use treatment
□ Prenatal Substance Use Prevention Program (PSUPP) – **1-800-433-0746**

5. Psycho-Neurological History

Check all that apply:

□ Clinical depression	□ Hx	□ Current
On meds?	□ Yes	□ No
□ Postpartum depression	□ Hx	□ Current
□ Suicide attempt/thought	□ Hx	□ Current
□ Borderline personality disorder	□ Hx	□ Current
□ Other Axis I diagnosis	□ Hx	□ Current

List _____
□ **If none of the above apply, please check here.**

6. Substance Abuse/Use History

Check all that apply:

□ Marijuana	□ Cocaine/crack
□ Amphetamines	□ Narcotics/heroin
□ Alcohol	□ Sedatives/tranq
□ Methadone	□ Inhalants/glue
□ Other_____	

If now using, are you ready to quit in the next 30 days? □ Yes □ No
□ **If none of the above apply, please check here.**

7. Tobacco History

Current cigarette/tobacco use	□ Yes	□ No
If yes, counseled on tobacco/smoking?	□ Yes	□ No
If you quit smoking, when did you quit (MM/DD/YYYY)? _____		
Counseled on second-hand smoke exposure?	□ Yes	□ No
Have you used cigarettes/ tobacco in the last 12 mos?	□ Yes	□ No
Are you ready to quit in the next 30 days?	□ Yes	□ No

8. Social Risk Factors

Have you been hit, slapped, kicked, or hurt during this pregnancy?	□ Yes	□ No
Do you feel safe in your own home?	□ Yes	□ No
In the past month, was there any day when you or anyone in your family went hungry because you didn't have enough money or food?	□ Yes	□ No

□ Homeless/lives in a shelter	□ Lives alone
□ Transportation problems	□ Unemployed
□ Education ≤ 10th grade	□ No phone
□ Learning disability/MR	□ Unstable home
□ Rape: □ Hx □ Current	□ No family support

□ **If none of the above apply, please check here.**

Person completing form (please print) :_____ **Date (MM/DD/YYYY) :** _____

MD signature: _____**Date (MM/DD/YYYY):** _____/_____/_____

Supplemental Information – Notification of Pregnancy

9. Diagnosis of Pregnancy Risk	5. Psycho-Neurological History
4. Current Medications	**6. Substance Abuse/Use History**