Notification of Pregnancy

Date of service: _____________

Member RID:

Delivery system: ◻ MDwise ◻ MHS ◻ Anthem ◻ FFS

Member name:

Physician name:

Race: ◻ White ◻ Black ◻ Am Indian ◻ Asian ◻ Other ____________________________________

Member address:

Physician telephone:

NPI/LPI:

Ethnicity: ◻ Hispanic ◻ Non-Hispanic

Pre-pregnancy weight (lbs)

Current weight (lbs)

Primary language: ◻ English ◻ Spanish ◻ Other_______________

Member telephone:

BMI > 30 ◻ Yes ◻ No
BMI < 19 ◻ Yes ◻ No

Height _______ ft ________ in

DOB (MM/DD/YYYY): ________________ **Age:________ yrs**

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

Toxicology ordered? ◻ Yes ◻ No

LMP (MM/DD/YYYY): ___________________
 # weeks pregnant ____________

Taking prenatal vitamins? ◻ Yes ◻ No

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**