



### PRENATAL NOTIFICATION FORM

Member Name \_\_\_\_\_ OB Provider \_\_\_\_\_  
 Member Phone # \_\_\_\_\_ OB Provider Phone \_\_\_\_\_  
 Member I.D. # \_\_\_\_\_ OB Provider Fax \_\_\_\_\_  
 Member DOB \_\_\_\_\_ OB Tax ID # \_\_\_\_\_

EDD \_\_\_\_ LMP \_\_\_\_\_ GRAVIDA \_\_\_\_ PARA \_\_\_\_ TERM \_\_\_\_ TERM \_\_\_\_ AB \_\_\_\_ L \_\_\_\_  
 FULL- PRE- Live

Initial Prenatal Visit Date \_\_\_\_\_ Primary Language Spoken \_\_\_\_\_

#### Current Pregnancy Risks

(please check if "yes")

- |  |   |
|--|---|
| <input type="checkbox"/> Preterm Labor                           | <input type="checkbox"/> Psychiatric/emotional disorder<br>specify: _____ |
| <input type="checkbox"/> Incompetent Cervix                      | <input type="checkbox"/> Domestic Violence                                |
| <input type="checkbox"/> Twins <input type="checkbox"/> Triplets | <input type="checkbox"/> Other Social Challenges specify _____            |
| <input type="checkbox"/> Gestational Diabetes                    | <input type="checkbox"/> I.U.G.R.   |
| <input type="checkbox"/> Placenta previa or vaginal bleeding     | <input type="checkbox"/> Substance Abuse specify _____                    |
| <input type="checkbox"/> Preeclampsia or P.I.H.                  | <input type="checkbox"/> Tobacco Use specify _____                        |
| <input type="checkbox"/> Under age 16                            | <input type="checkbox"/> Alcohol Use specify _____                        |
| <input type="checkbox"/> Over age 35                             | <input type="checkbox"/> Nutritional Deficit specify _____                |
| <input type="checkbox"/> Fetal anomaly specify _____             | <input type="checkbox"/> Other Risk specify _____                         |

#### Previous Pregnancies

(please check if "yes")

- |  |  |
|--|--|
| <input type="checkbox"/> Preterm Labor # weeks _____             | <input type="checkbox"/> Previous low birthweight weight _____                 |
| <input type="checkbox"/> Preterm delivery # weeks _____          | <input type="checkbox"/> Congenital anomaly specify _____                      |
| <input type="checkbox"/> PROM or PPRM # weeks _____              | <input type="checkbox"/> Placenta previa <input type="checkbox"/> abruptio     |
| <input type="checkbox"/> Incompetent cervix                      | <input type="checkbox"/> Preclampsia <input type="checkbox"/> P.I.H.           |
| <input type="checkbox"/> Spont. AB or Fetal demise # weeks _____ | <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Previous C-Section Reason _____         | <input type="checkbox"/> Other _____   |

#### Current Medical Conditions

(please check if "yes")

- |  |   |
|--|---|
| <input type="checkbox"/> H.I.V. or A.I.D.S. _____                            | <input type="checkbox"/> STD _____                      |
| <input type="checkbox"/> Asthma _____  | <input type="checkbox"/> Mental/Emotional Illness _____ |
| <input type="checkbox"/> Substance abuse rehab _____                         | <input type="checkbox"/> Cardiac Condition _____        |
| <input type="checkbox"/> Chronic hypertension _____                          | <input type="checkbox"/> Neurological condition _____   |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin dependent | <input type="checkbox"/> Other _____                    |

#### Health Screening

Current Medications \_\_\_\_\_ Domestic Violence screening? \_\_\_\_\_  
 HIV Tested? \_\_\_\_\_ Test declined? \_\_\_\_\_ W.I.C. Referral given? \_\_\_\_\_

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 Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

**\*\*Note to OB Provider:** This form generates a pregnancy notification. It should be submitted to WellCare within 30 days of the initial prenatal visit to expedite member's placement into WellCare's Prenatal and/or High Risk Program.