



PREGNANCY NOTIFICATION FORM

Earliest completion of this form allows the Pregnancy Care Program to best utilize our resources and services to support you and your patient in achieving healthy pregnancy outcomes. **Please fax form to: 866-601-3871**

Date: ___/___/___

OB Provider _____ ID Number _____

Address _____ Phone Number _____

ENROLLEE INFO

Medicaid Number _____ DOB ___/___/___

Last Name _____ First Name _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

Preferred Language (if other than English) _____ Interpreter Needed (Y/N) _____

Date of 1st Prenatal Care Visit ___/___/___ EDD ___/___/___ Height ___ft. ___in. Pre-Pregnancy Weight _____

Number of Full Term Deliveries _____ Healthy Start Prenatal Screen Completed? (Y/N) _____

Number of Preterm Deliveries* _____ Healthy Start Referral? (Y/N) _____

Number of Miscarriages/Abortions _____ WIC Referral Completed? (Y/N) _____

Number of Stillbirths _____

Previous C-Section(s) No Yes If yes, how many? _____

***To prior authorize Makena, please call 844-716-5385 or fax 866-265-5511**

PREGNANCY RISK ASSESSMENT

Active Medical/Behavioral Health Conditions

- Diabetes – Pregestational
- Chronic Hypertension
- Asthma
- Systemic Lupus Erythematosus
- Seizure Disorder Seizure within last 6 months
- Chronic Renal Disease
- Cardiac Disease
- Thyroid Disease
- Sickle Cell Disease

Current Pregnancy

- Young Maternal Age < 18 Years of Age
- Underweight – BMI < 18.5
- Obesity Class III – BMI > 40
- Short Interpregnancy Interval 6-12 Months
- Short Interpregnancy Interval < 6 Months
- Gestational Diabetes
- Hypertensive Disorder of Pregnancy*
- *Please Specify _____
- Multiple Gestation Twins Triplets Higher Order

Active Medical/Behavioral Health Conditions

- HIV Negative Positive Refused Testing
- Serious Mental Illness or Severe Emotional Disturbance*

*Please Specify _____

- Depressive Disorder – Mild/Moderate
- Anxiety Disorder – Mild/Moderate
- Sexually Transmitted Infection*

*Please Specify _____

Pregnancy History

- Preterm Spontaneous Delivery < 37 Weeks*
- *Currently on 17P/Makena (Y/N) _____
- Cervical Insufficiency in previous pregnancy
- Fetal death ≥ 20 weeks (stillbirth) in previous pregnancy
- Gestational Diabetes in previous pregnancy
- Hypertensive Disorder of Pregnancy in previous pregnancy
- Postpartum Depression in previous pregnancy

Current Pregnancy

- Shortened Cervix/Cervical Insufficiency
- Abnormal Placenta*

*Please Specify _____

- Congenital Anomalies*
- *Please Specify _____

- Fetal Growth Restriction or Oligohydramnios
- Preterm Dilation of Cervix/Labor
- Substance Use < 3 months prior to pregnancy
- Substance Use/Substance Use Disorder*

*Please Specify _____

- Opioid Therapy*
- *Please Specify _____

Alcohol Use Amount _____

Prescription Opioid Use*

*Please Specify _____

- Tobacco or Electronic Nicotine Delivery System Use
- Homelessness/Unstable Housing
- Domestic/Interpersonal Violence
- Late Entry into Prenatal Care > 14 Weeks
- Inconsistent Prenatal Care
- Unwanted Pregnancy
- Lack of Transportation
- Financial Insecurity
- Food Insecurity

Other Significant Risk Factors or Barriers to Care No Yes Please list below