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: 888-854-3929**

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 888-854-3929**

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

Enrollee_____ DOB ___/___/____

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