

STI history				Current medications	
	Screen date:	Negative	Positive	<input type="checkbox"/> No medications	
<input type="checkbox"/> HIV:	_____	<input type="checkbox"/>	<input type="checkbox"/>	Please list: _____	
<input type="checkbox"/> Syphilis:	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/> Gonorrhea:	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/> Chlamydia:	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	

Provider information		
Last name:	First name:	Tax ID number:
Phone number:	Fax number:	Delivery hospital:
Address:		City, state, ZIP code:

Is the provider requesting care coordination? Yes No

Provider (MD/DO/APRN/PA): _____ Date: _____



Please complete the enclosed form for each of your pregnant patients who are UnitedHealthcare Community Plan members within 15 calendar days of the member's first prenatal visit. Fax each form to **877-353-6913**.

For faster service, sign in to the UnitedHealthcare Provider Portal and use the Care Conductor tool for pregnancy notification and risk assessment.