

UnitedHealthcare Community Plan

Obstetrical Needs Assessment (ONAF)

FAX Information

Date initially faxed: _____ Post Partum Fax Date: _____

Member name (first, middle initial, last)

Date of birth

Member ID#

Home phone #

Alternate phone #

Hospital for Delivery

Gestational age 1st visit

weeks

Date of 1st Prenatal Visit

EDC date

Gravida

Para

Live births

TAB

17-P Candidate?

Yes No

Date Last PAP

Date Last Chlamydia Screen

Date Last Mammogram

Dental visit past 6 mos?

Yes No

WIC

Yes No

Provider# EIN

Practice Name:

Practice Phone #

Practice FAX#

Past OB Complications	Current Risks		Active Maternal Medical Disorders	
<input type="checkbox"/> Gestational Diabetes	2 nd /3 rd trimester bleeding	<input type="checkbox"/>	Anemia Hgb<10	<input type="checkbox"/>
<input type="checkbox"/> Incompetent cervix	Placental Abnormalities	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
<input type="checkbox"/> IUGR	Gestational Diabetes	<input type="checkbox"/>	Cardiac disease (specify):	<input type="checkbox"/>
<input type="checkbox"/> Pregnancy Induced Hypertension	Missed Prenatal Care Visit	<input type="checkbox"/>	Chronic hypertension	<input type="checkbox"/>
<input type="checkbox"/> Premature ROM	Perinatal depression	<input type="checkbox"/>	Clotting disorder (specify):	<input type="checkbox"/>
<input type="checkbox"/> Preterm delivery <32 wks	Periodontal disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/> Preterm delivery 32-36 wks	Inadequate weight gain	<input type="checkbox"/>	Hepatitis (specify):	<input type="checkbox"/>
<input type="checkbox"/> Preterm labor <32 wks	Pregnancy Induced Hypertension	<input type="checkbox"/>	HIV	<input type="checkbox"/>
<input type="checkbox"/> Previous C-Section	Premature ROM	<input type="checkbox"/>	Renal disease (specify):	<input type="checkbox"/>
<input type="checkbox"/> Recurrent 2 nd trimester loss	Preterm Labor <32 weeks or PT dilation of cervix >1.5cm	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>
Prenatal Visit Dates	Previous delivery within 1 year	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Social, Economic, Lifestyle Risks		STD (specify):	<input type="checkbox"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Currently Using Tobacco	<input type="checkbox"/>	Thyroid disease (specify):	<input type="checkbox"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Cessation Services Offered	<input type="checkbox"/>	Other medical/social issues:	<input type="checkbox"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Domestic violence	<input type="checkbox"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Eating disorder (specify)	<input type="checkbox"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	History of chronic depression	<input type="checkbox"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Homelessness	<input type="checkbox"/>	Postpartum Visit (Should be between 21-56 days after delivery)	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Mental health disorder (specify)	<input type="checkbox"/>	Date of post partum visit:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Currently on Medication	<input type="checkbox"/>	Feeding Method	Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both <input type="checkbox"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Mental retardation	<input type="checkbox"/>	Postpartum depression present <input type="checkbox"/>	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	English not primary language	<input type="checkbox"/>	Postpartum Contraception Discussed <input type="checkbox"/>	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Alcohol use	<input type="checkbox"/>	Quit Tobacco During Pregnancy & Remains Tobacco Free	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Street or Rx Drug Use	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Teen pregnancy with Head of Household awareness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Substance Abuse Screen	Yes <input type="checkbox"/> No <input type="checkbox"/>	Community referrals made:	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Depression Screening completed	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Instructions for Completion of ONAF

Purpose:

Initial health plan notification of a member pregnancy by Provider office
(Form may be completed by office/clinical staff other than the treating provider)

Process:

First form submission (within 5 days of initial office visit)

- Complete the demographics section in its entirety
- Complete the clinical section noting which risk or medical conditions are identified during the first prenatal visit.

Subsequent form submissions to document**

- Newly identified risks (note trimester identified)
- Dates of subsequent office visits
- Post partum visit information
- Specific instructions or concerns throughout pregnancy

**Subsequent submissions may either be on a new form with completed member and provider demographics *or* added to the original form and re faxed.

Healthy First Steps® (HFS) UHC maternity care management program

It is our desire to partner with providers, members and community resources to achieve optimal maternal and birth outcomes. Your *prompt notification* of pregnancy and clinical information enables earlier member contact to discuss and enroll in the HFS program.

Experienced OB Case Managers provide education regarding medical and emotional aspects of pregnancy, how to recognize and report complications and assistance with transportation and other community-based services. Compliance with appointments and provider treatment plans are always discussed during telephone calls. We encourage and welcome your interaction/feedback related to specific member instructions or concerns throughout the pregnancy. We also welcome the opportunity to provide additional information related to the HFS program.

Healthy First Steps FAX

877 353 6913

Healthy First Steps Phone

800 599 5985