Obstetrics risk assessment

All questions contained in this questionnaire are strictly confidential and will become part of your medical records.

Date assessment completed:

Patient demographics

Patient name			Insurance ID/ Medicaid #:
Last:	**First:**	**M.I.:**	**DOB:**
Street address:	**City:**	**State:**	**ZIP code:**
Home phone:	**Cell phone:**		
Race/ethnicity: ❑ African American ❑ Caucasian ❑ Native Hawaiian ❑ Asian ❑ Multi-racial ❑ Chuukese ❑ Marshallese ❑ Other		**Primary language**	❑ English ❑ Filipino ❑ Other_____

Provider demographics

Practice name	Provider name/type:	NPI/TIN:	Office location:
	Provider signature:		

Patient information

Date of first prenatal visit:	Estimated due date:	Gravida:	Para:

Medical conditions (check all that apply)

❑ Diabetes ❑ Prediabetes ❑ Hypertension ❑ Asthma ❑ STD ❑ HIV ❑ Other_____

Obstetrical considerations (check all that apply)

❑ Hx preterm delivery ❑ Candidate for progesterone therapy ❑ Hx C-section, indication:_____ ❑ Bleeding after 12 weeks
❑ Multiple gestation ❑ Incompetent cervix ❑ Genetic risk ❑ Other_____

Behavioral status (check all that apply)

❑ Anxiety ❑ Depression ❑ Other psychiatric diagnosis ❑ SUD ❑ Smoking ❑ Other_____

Social conditions (check all that apply)

❑ Domestic violence ❑ Other support system needs ❑ Homelessness ❑ Lack of transportation ❑ Other resource needs
❑ Known to state social service system Other_____

Plan of care

Plan of care item	Referred	Enrolled	Completed	Refused
❑ Preterm labor prevention	❑	❑	❑	❑
❑ Domestic violence assistance	❑	❑	❑	❑
❑ Substance use disorder treatment	❑	❑	❑	❑
❑ Mental health support	❑	❑	❑	❑
❑ Childbirth education	❑	❑	❑	❑
❑ Other community resources	❑	❑	❑	❑
❑ SSI	❑	❑	❑	❑
❑ Smoking cessation	❑	❑	❑	❑
❑ Diabetes care	❑	❑	❑	❑
❑ MFM/other specialist	❑	❑	❑	❑
❑ Nutrition consultation	❑	❑	❑	❑
❑ Breastfeeding education	❑	❑	❑	❑
❑ WIC	❑	❑	❑	❑

Additional notes

How can we help you?

The Hapai Malama program is available to assist with complications or barriers you identify during your patient's pregnancy and postpartum period. For more information, call Provider Services at **888-980-8728 (TYY users: 711).**

To notify UnitedHealthcare of a member's pregnancy electronically, submit this form through the UnitedHealthcare Provider Portal at **UHCprovider.com/portal.** Sign in with your One Healthcare ID and go to the simple form under Care Conductor and Notification of Pregnancy.

Or complete and fax this form to 877-353-6913.

UnitedHealthcare® Community Plan