

Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. Please complete clearly in black ink and fax to:

Louisiana Healthcare Connections 1-866-681-5125 Healthy Blue 1-800-964-3627
Aetna Better Health 1-888-858-3875 AmeriHealth Caritas 1-888-877-5925
United Healthcare 1-877-353-6913

Member Info *required field Member ID*

Last Name aaaa First Name aa

DOB (mmddyyyy) _____ Mailing Address aaaaaaaa aa

City aaaaa State aa Zip aaaaa

Home Phone aaa - aaa - aaaa Cell Phone aaa - aaa - aaaa

Email Address aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa

Due Date* (mmddyyyy) _____ Preferred Language (if other than English) _____

Date of first Prenatal Visit (mmddyyyy) _____ Pre-Pregnancy Weight aaa

Race/Ethnicity (fill in all that apply) White Black/African American Hispanic/Latina American Indian/Native American
Asian Hawaiian/Pacific Islander Other Please specify _____

Number of Full Term Deliveries aa Number of Stillbirths aa

Number of Pre-Term Deliveries aa Number of Miscarriages/Abortions aa

Pregnancy risk assessment

Are any of the following risk factors present? *If there are no known risk factors, Please fill in here*

History (fill in all that apply):

- Previous Pre-Term (<37 weeks) delivery?.....
- If yes, was the delivery spontaneous?.....
- Is the member a candidate for progesterone injections?...
- Recent delivery (within past 12 months)?.....
- Previous C-Section?.....
- Diabetes (prior to pregnancy)?.....
- Sickle Cell?.....
- Asthma?.....
- High Blood Pressure (prior to pregnancy)?.....
- HIV positive?.....
- Seizure disorder?.....
- Seizure within the last 6 months?.....
- Previous alcohol or drug abuse?.....

Current Pregnancy (fill in all that apply):

- Pre-Term labor this pregnancy?.....
- Shortened Cervix < 23 weeks this pregnancy?.....
- Length aa
- Cervical Cerclage placement?.....
- Twins? Triplets? Discordant?
- Current severe hyperemesis?.....
- Current mental health concerns?.....
- List _____
- Current STD? List
- Current tobacco use? Amount
- Current alcohol use? Amount
- Current street drug use?.....



Date (mmddyyyy) _____

OB Provider name* aaaaaaaa aaaaaaaaaaaaaaaaaaaa

TIN/ID number* a Phone number aaa - aaa - aaaa

Mailing Address aaaaaaaa aaaaaaaaaaaaaaaaaaaa

City aaaaaaaa State a Zip Code aaaa