



OBSTETRICS RISK ASSESSMENT

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

Complete and fax this form to: (877)353-6913

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:	<input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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)					
<input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> STD <input type="checkbox"/> HIV <input type="checkbox"/> Other _____					
Obstetrical Considerations (check all that apply)					
<input type="checkbox"/> Hx preterm delivery <input type="checkbox"/> Candidate for progesterone therapy <input type="checkbox"/> Hx C-section, indication: _____ <input type="checkbox"/> Bleeding after 12 weeks <input type="checkbox"/> Multiple gestation <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> Genetic risk <input type="checkbox"/> Other _____					
Behavioral Status (check all that apply)					
<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other psychiatric diagnosis <input type="checkbox"/> SUD <input type="checkbox"/> Smoking <input type="checkbox"/> Other _____					
Social Conditions (check all that apply)					
<input type="checkbox"/> Domestic Violence <input type="checkbox"/> Other support system needs <input type="checkbox"/> Homelessness <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Other resource needs <input type="checkbox"/> Known to state social service system <input type="checkbox"/> Other _____					
Plan of Care			Additional Notes		
POC Item	Referred	Enrolled	Completed	Refused	
<input type="checkbox"/> Preterm labor prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Domestic violence assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substance use disorder treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental health support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Childbirth education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> SSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Smoking cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Diabetes care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> MFM/other specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Nutrition consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Breastfeeding education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
How Can We Help You?					
The Healthy First Steps program is available to assist with complications or barriers you identify during the course of your patient's pregnancy and postpartum period. You can reach a Healthy First Steps representative by calling (800) 599-5985 .					