Contact the Regional Maternal and Child Health Consortia and the NJ Prevention Network for behavioral health referral assistance:

Northern New Jersey MCH Consortium: (201) 843-7400
Hudson Perinatal Consortium: (201) 876-8900
Gateway/Northwest MCH Consortium: (973) 268-2280
Central New Jersey MCH Consortium: (732) 937-5437
Regional Perinatal Consortium of Monmouth and Ocean Counties: (732) 363-5400
Southern New Jersey Perinatal Cooperative: (856) 665-6000

Delivery Site Codes: *(By County)*

Atlantic County
395 - AtlantiCare Regional Medical Center – Mainland
700 - Shore Memorial Hospital

Bergen County
180 - Englewood Hospital and Medical Center
270 - Hackensack University Medical Center
290 - Holy Name Hospital
095 - The Childbirth Center
830 - The Valley Hospital

Burlington County
602 - Lourdes Medical Center of Burlington County
080 - Virtua Memorial Hospital of Burlington County

Camden County
115 - Cooper University Hospital
508 - Our Lady of Lourdes Medical Center
897 - Virtua West Jersey Hospital – Voorhees

Cape May County
077 - Cape Regional Medical Center

Cumberland County
485 - South Jersey Regional Medical Center

Essex County
385 - Clara Mass Medical Center
055 - Newark Beth Israel Medical Center
640 - St. Barnabas Medical Center
470 - The Mountainside Hospital
480 - UMDNJ - University Hospital

Gloucester County
800 - Underwood Memorial Hospital
887 - Kennedy Memorial Hospitals UMC – Washington Twp

Hudson County
050 - Bayonne Medical Center
100 - Christ Hospital
670 - Hoboken University Medical Center
433 - Jersey City Medical Center – Wilzig Hospital
609 - Meadowlands Hospital Medical Center
502 - Palisades Med Ctr – NY Presbyterian Healthcare System

Hunterdon County
305 - Hunterdon Medical Center

Mercer County
440 - Capital Health System – Mercer Campus
770 - RWJ University Hospital at Hamilton
570 - University Medical Center at Princeton

Middlesex County
333 - JFK Medical Center
555 - Raritan Bay Medical Center
445 - RWJ University Hospital
685 - St. Peter's University Hospital

Monmouth County
215 - Central State Healthcare System
220 - Jersey Shore University Medical Center
610 - Riverview Medical Center
455 - Monmouth Medical Center

Morris County
097 - Chilton Memorial Hospital
465 - Morristown Memorial Hospital
643 - St. Clare's Hospital/Denville

Ocean County
122 - Community Medical Center
550 - Kimball Medical Center
070 - Ocean Medical Center
626 - Southern Ocean County Hospital

Passaic County
660 - St. Joseph's Regional Medical Center
249 - St. Joseph's Wayne Hospital
675 - St. Mary's Hospital

Salem County
177 - South Jersey Hospital – Elmer
695 - The Memorial Hospital of Salem County

Somerset County
705 - Somerset Medical Center

Sussex County
490 - Newton Memorial Hospital

Union County
475 - Muhlenberg Regional Medical Center
510 - Overlook Hospital
645 - Trinitas Hospital

Warren County
275 - Hackettstown Regional Medical Center
885 - Warren Hospital

WHEN FORM IS COMPLETED, FAX DAILY TO: 856-662-4321

13264

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PERINATAL RISK ASSESSMENT

PLEASE PRINT CLEARLY *REQUIRED FOR FORM PROCESSING*

Date Form Completed (M M - D D - Y Y) | SSN | Insurance ID/Medicaid # | Insurance Effective Date (M M - D D - Y Y)

Patient Information
Last Name* | First Name* | Date of Birth* (M M - D D - Y Y)
Street Address* | City*
Zip Code* | County | Home / Cell Phone* | Work Phone
Emergency Contact Name* | Emergency Contact Phone*
Name of Father of the Baby
Father of Baby Involved . . . . ○ Yes ○ No
Married . . . . . ○ Yes ○ No

Provider Information*
Provider FAX # | Provider Phone # | Provider Zip Code | Planned Delivery Site Code
Provider Chart # | NPI # / Provider # | Screener: First Initial and Last Name

Race/Ethnicity *(choose one)*
○ African American ○ Multi-Racial
○ Caucasian ○ Hispanic
○ Asian ○ Other
○ Native American

Primary Language *(choose one)*
○ English
○ Spanish
○ Other *(specify)*_____

Health Insurance* *(Select all that apply)*
○ Medicaid PE ○ Medicare
○ Medicaid FFS ○ NJ Family Care
○ Medicaid MC ○ Commercial
○ Uninsured/Self-Pay

MCO* *(choose one for Medicaid Eligibles)*
○ None ○ Health Net
○ AmeriChoice ○ Horizon NJ Health
○ AmeriGroup ○ University Health Plans

Entry Into Prenatal Care
Date of* first visit (M M - D D - Y Y)
Date of 1st visit under MCO (M M - D D - Y Y)
LMP* (M M - D D - Y Y)
EDC* (M M - D D - Y Y)

Physical Assessment
Blood Pressure ___ / ___
Pre Pregnancy Weight (lbs)
Current Weight (lbs)
Height (Ft-Inches) ___ - ___

Perinatal History
Gravida* | Para* (T P SAB EAB L)
Date of most recent live birth (M M - D D - Y Y)
Weeks Gestation of Preterm loss(es): *select any that apply*
○ <21 wks ○ 21-34 wks ○ >34 wks
Specify # of Weeks Gestation of most advanced loss:

Oral Health and Referral

	Yes	No
Sensitive/Bleeding Gums	○	○
Dental Referral Given	○	○
Patient Education Given	○	○
Visit within the last year	○	○

Pregnancy Risk Factors ○ ***All Risk Factors Negative***

	Current Preg Y	Current Preg N	Prior Preg Y	Prior Preg N	Family History Y	Family History N
Previous Cesarean Section	na	na	○	○	na	na
Low Birth Weight (<2500gm)	na	na	○	○	na	na
History of PROM	na	na	○	○	na	na
Hyperemesis	○	○	○	○	na	na
Obesity	○	○	○	○	na	na
Gestational Diabetes	○	○	○	○	na	na
PIH/Preeclampsia	○	○	○	○	na	na
Placenta Previa	○	○	○	○	na	na
Cervical Incompetence	○	○	○	○	na	na
Ectopic Pregnancy	○	○	○	○	na	na
Multiple Gestation	○	○	○	○	○	○
Fetal Reduction	○	○	○	○	na	na
Macrosomia	○	○	○	○	na	na
IUGR	○	○	○	○	na	na
Oligo/Polyhydramnios	○	○	○	○	na	na
Abnormal Amniocentesis	○	○	○	○	na	na
Abnormal AFP	○	○	○	○	na	na
Maternal Fetal Infection	○	○	○	○	na	na
Abdominal Surgery	○	○	○	○	na	na
Fetal Genetic/Structural abnormalities	○	○	○	○	○	○
Rh Negative	○	○	○	○	na	na
Hepatitis B	○	○	○	○	na	na
Group B Strep	○	○	○	○	na	na
Opioid Replacement Treatment	○	○	○	○	na	na
Pyelonephritis	○	○	○	○	na	na
Urinary Tract Infection	○	○	na	na	na	na
Assisted Reproductive Technology	○	○	na	na	na	na
Bleeding during current pregnancy	○ 1st	○ 2nd	○ 3rd	○ No		

FHI ID 107501 13264

DO NOT PHOTOCOPY BLANK FORMS **PLEASE COMPLETE AND FAX TO: 856-662-4321**

FHI PRA 0409

The Perinatal Risk Assessment (PRA) form serves as the authorization form for:

- AmeriChoice
- AmeriGroup
- Health Net
- Horizon NJ Health and
- University Health Plans

The PRA form must be completed by the treating obstetric service provider. Accurate completion will expedite continuity of treatment and care for mother and baby. Detailed information about the PRA form and process, including a list of Definitions and Descriptions are included in the Perinatal Risk Assessment Form Training Manual.

General Instructions

- Fill in circles completely
- Print clearly and inside the box
- Information written outside of designated areas will not be transmitted
- If information is not applicable, leave space blank
- Do not use a stamp to complete any section of the form
- **Do not photocopy blank PRA forms**

Specific Instructions

Fields required for submission to FHI:

- Patient name and address
- Date of birth
- At least one phone number
- Provider Fax and phone number
- Date of first visit (date of initial prenatal medical examination)
- EDC (Date of Expected Delivery)
- LMP (Last Menstrual Period)
- If Gravida >2, must complete Para

Additional fields required for submission to insurer:

- Health Insurance
- MCO

The only fields that can be left blank:

- Insurance Effective Date: if not enrolled in a MCO when the form is completed
- Name of Father of the Baby if unknown

At least one phone contact number is required

SSN
Not a US citizen: enter **0** (zero) in every block
If a US citizen refuses to give SSN: enter **9** (nine) in every block

Provider Information
Planned Delivery Site Code: Listed by county at the end of Instructions
Provider Fax number: used to identify prenatal provider site for authorization

Health Insurance
Medicaid
PE - Presumptively Eligible
FFS - Fee For Service
MC - Medicaid Managed Care

Perinatal History:
Gravida: number of pregnancies
Para: number of
(T) - term deliveries
(P) - preterm deliveries
(SAB) - spontaneous abortions
(EAB) - elective terminations
(L) - live births

✙ Current Medications:
List current medications indicated in the Medical Conditions Section. Dosage not required

⌘Additional Critical Information:
Must specify: allergies, disabilities and mental health conditions that are critical to prenatal case management.

Plan of Care
Completed/Enrolled: Has been assessed or is currently receiving service
Referred - referral made, accepted by patient
Refused - referral given, patient refused

HMO Members Services Contact Information:
AmeriChoice: 1 800-905-4315
AMERIGROUP: 1 800-600-4441
Health Net: 1 203-225-3988
Horizon NJ Health: 1 800-682-9094
University Health Plans Inc: 1 800-780-2438

WHEN FORM IS COMPLETED, FAX DAILY TO: 856-662-4321

13264

Provider Chart #

Current Medical Conditions

○ *All Risk Factors Negative*

	Yes	No	✙On Meds	Patient History	Family History		Yes	No	✙On Meds	Patient History	Family History		Yes	No	✙On Meds	Patient History	Family History
Neurological Condition	○	○	○	○	na	Phlebitis/DVT	○	○	○	○	na	Renal Disease	○	○	○	○	na
Seizures	○	○	○	○	○	Anemia	○	○	○	○	na	Lupus	○	○	○	○	na
Depression/Mental Illness⌘	○	○	○	○	○	Blood Dyscrasia	○	○	○	○	na	Cancer	○	○	○	○	○
Asthma	○	○	○	○	na	Diabetes	○	○	○	na	○	Uterine Abnormalities	○	○	○	○	na
Tuberculosis	○	○	○	○	na	Thyroid Disease	○	○	○	○	○	Abnormal Pap Smear	○	○	○	○	na
Cystic Fibrosis	○	○	○	○	○	Sickle Cell Trait	○	○	○	○	○	STD	○	○	○	○	na
Heart Condition	○	○	○	○	○	Sickle Cell Disease	○	○	○	○	na	AIDS	○	○	○	na	na
Chronic Hypertension	○	○	○	○	na	Liver Disease	○	○	○	○	na	Allergies⌘	○	○	○	○	na

HIV — HIV Positive: Y ○ N ○ ✙On Meds ○ | Date HIV Test Given: M M - D D - Y Y | Refused ○

Psychosocial Risk Factors

○ *All Risk Factors Negative*

	Yes	No		Yes	No		Yes
Disabled⌘	○	○	Transportation	○	○	Insurance Enrollment Delay	○
Unemployed/Inadequate Income	○	○	Inadequate Social Support	○	○	Unaware of importance of PNC	○
Husband/Partner is Unemployed	○	○	Unplanned Pregnancy	○	○	Financial	○
Homeless	○	○	Nutritional Concerns	○	○	Child Care Issues	○
Unstable Housing	○	○	Perinatal Depression	○	○	Couldn't find a health provider	○
Education <12 years	○	○	Eating disorder	○	○	Access to pregnancy testing	○
Currently in Foster Care	○	○	Domestic Violence	○	○	Abortion desired/unsuccessful	○
						Transportation	○

Reason for Late Entry into Prenatal Care (*2nd or 3rd trim*)

Environmental Exposures

	Yes	No
Lead:		
Home built before 1978	○	○
Viral:		
Cats or Birds in Home	○	○
Tobacco:		
2nd or 3rd Hand Smoke	○	○

*4Ps Plus

	Yes	No		Yes	No
Did either of your parents have a problem with drugs or alcohol	○	○	Have you ever drunk beer/wine/liquor	○	○
Does your partner have any problem with drugs or alcohol	○	○			
Have you ever felt manipulated by your partner	○	○	In the month before you knew you were pregnant	*Any	None
Have you ever felt out of control or helpless	○	○			
Over the past 2 weeks			how many cigarettes did you smoke	○	○
have you felt down, depressed or hopeless	○	○	how much beer/wine/liquor did you drink	○	○
have you felt little interest or pleasure in doing things	○	○	how much marijuana did you use	○	○

***If an *Any is checked, continue with the 4Ps Follow-Up Questions.**

4 Ps Plus Follow-up Questions (if an *Any above was checked)

In the month before you knew you were pregnant :	Refer for Assessment: Every Day	Refer for Assessment: 3-6 Days/wk	Prevention Education: 1-2 days/wk	Prevention Education: <1 day/wk	No Referral Needed (did not drink/use drugs)
About how many days a week ***did you*** usually drink beer / wine / liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○
And now, about how many days a week ***do you*** usually drink beer / wine / liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○

Plan of Care

	Completed/ Enrolled	Referred	Refused		Completed/ Enrolled	Referred	Refused
Tobacco Cessation	○	○	○	SSI	○	○	○
Substance Abuse Prevention Ed	○	○	○	DYFS	○	○	○
Substance Abuse Assessment	○	○	○	Community Home Visiting	○	○	○
Mental Health Assessment	○	○	○	Preterm Labor Prevention	○	○	○
Domestic Violence Assessment	○	○	○	Diabetes Care Program	○	○	○
TANF/GA	○	○	○	Nutritional Consult	○	○	○
Emergency Assistance	○	○	○	Breast Feeding Consult	○	○	○
Food Stamps	○	○	○	Maternal Fetal Medicine Consult	○	○	○
WIC	○	○	○	Childbirth Education	○	○	○

✙ Current Medications — PLEASE PRINT CLEARLY

⌘Additional Critical Information

FHI ID 107501

13264

DO NOT PHOTOCOPY BLANK FORMS **PLEASE COMPLETE AND FAX TO: 856-662-4321**

4Ps Plus 1999 National Training Institute USPAT pending No 29107188