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

Provider# EIN ☐☐☐☐☐☐☐☐☐☐☐☐☐

Practice Name: _____

Practice Phone # ☐☐☐ ☐☐☐-☐☐☐☐

Practice FAX# ☐☐☐ ☐☐☐-☐☐☐☐

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

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

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