UnitedHealthcare Community Plan

Virginia obstetrical risk assessment form

Member information

Member ID number: _____

Last name:	First name:	MI:	DOB (mm/dd/yyyy):	Telephone number:
Address:	City, state, ZIP code:			
Email:	Date of initial prenatal visit/Diagnosis date:	Completion date of pregnancy		

Pregnancy information and history

LMP	Gestational age at first visit	EDC	Gravida	Para	Pre-term	Living	Abortions
							Spontaneous:____ Induced:____

Risk factors (past or current)

- ☐ No risk factors
- ☐ Diabetes/GDM/LGA baby
- ☐ DVT/PT
- ☐ Eclampsia/Pre-eclampsia
- ☐ Fetal congenital anomaly or disorder
- ☐ Fetal death
  - ☐ Second trimester ☐ Third trimester
- ☐ Hypertension/GHTN
- ☐ Incompetent cervix
- ☐ IUGR/SGA baby
- ☐ Late and/or inconsistent prenatal care
- ☐ Low birth weight < 2500 grams
- ☐ Multiple gestation
- ☐ Placenta abnormalities
  - ☐ Abruption ☐ Previa
- ☐ Premature ROM
- ☐ Pre-term (specify gestational age)
  - ☐ Delivery: _____
  - ☐ Labor: _____
- ☐ Renal disease
- ☐ Sickle cell disease/trait
- ☐ Abnormal ultrasound: _____
- ☐ Uterine abnormality: _____
- ☐ Other: _____

Active medical conditions

- ☐ None
- ☐ Advanced maternal age
- ☐ Asthma
- ☐ Auto-immune disease(s) _____
- ☐ BMI (low or high): _____
- ☐ Hepatitis
- ☐ HIV
- ☐ Seizure disorder: _____

Thyroid disease - treated?

- ☐ Yes ☐ No
- ☐ Other (specify): _____

Social, economic and lifestyle factors

- ☐ No risk factors
- ☐ Behavioral health condition _____
- ☐ Domestic violence
- ☐ Housing issues
- ☐ Identified social, economic and lifestyle _____
- ☐ Intellectual impairment
- ☐ Lack of support system
- ☐ Literacy issues
- ☐ Mental/physical/sexual abuse (current or history of): _____
- ☐ Postpartum depression
- ☐ Smoking/vaping/tobacco use; individualized intervention offered?
  - ☐ Yes ☐ No
- ☐ Substance use:
  - ☐ Alcohol: _____
  - ☐ Drug: _____
- ☐ Teen pregnancy: _____
- ☐ Other (specify): _____

Sexually transmitted infection (STI) history

	Screen date	Negative	Positive
☐ HIV:	_____	☐	☐
☐ Syphilis:	_____	☐	☐
☐ Gonorrhea:	_____	☐	☐
☐ Chlamydia:	_____	☐	☐

Current medications

- ☐ No medications

Please list: _____

Provider information

Provider name:	Tax ID number:	Phone number:	Fax number:	Delivery hospital:
Address:	City, state, ZIP code:			

Provider requesting care coordination: ☐ Yes ☐ No

Provider (MD/DO/APRN/PA): _____ Date: _____

Please complete and fax the enclosed form for each of your pregnant patients who are UnitedHealthcare Community Plan members within 10 days of the member's first prenatal visit. Please fax each form to 877-353-6913.