

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)

Active Medical Conditions

Social, Economic and Lifestyle Factors

<input type="checkbox"/> No Risk Factors <input type="checkbox"/> Diabetes/GDM/LGA baby <input type="checkbox"/> DVT/PT <input type="checkbox"/> Eclampsia/Pre-eclampsia <input type="checkbox"/> Fetal congenital anomaly or disorder <input type="checkbox"/> Fetal death <input type="checkbox"/> Second trimester <input type="checkbox"/> Third trimester <input type="checkbox"/> Hypertension/GHTN <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> IUGR/SGA baby <input type="checkbox"/> Late and/or inconsistent prenatal care <input type="checkbox"/> Low birth weight < 2500 grams <input type="checkbox"/> Multiple gestation <input type="checkbox"/> Placenta abnormalities <input type="checkbox"/> Abruption <input type="checkbox"/> Previa <input type="checkbox"/> Premature ROM <input type="checkbox"/> Pre- term (specify gestational age) <input type="checkbox"/> Delivery: _____ <input type="checkbox"/> Labor: _____ <input type="checkbox"/> Renal Disease <input type="checkbox"/> Sickle cell disease/trait <input type="checkbox"/> Abnormal ultrasound: _____ <input type="checkbox"/> Uterine abnormality: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> None <input type="checkbox"/> Advanced maternal age <input type="checkbox"/> Asthma <input type="checkbox"/> Auto- immune disease(s) <input type="checkbox"/> BMI (low or high): _____ <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Seizure disorder: _____ Thyroid disease - treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (specify): _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No Risk Factors <input type="checkbox"/> Behavioral health condition <input type="checkbox"/> Domestic violence <input type="checkbox"/> Housing issues <input type="checkbox"/> Identified social, economic and lifestyle <input type="checkbox"/> Intellectual impairment <input type="checkbox"/> Lack of support system <input type="checkbox"/> Literacy issues <input type="checkbox"/> Mental/physical/sexual abuse (current or history of): _____ <input type="checkbox"/> Postpartum depression <input type="checkbox"/> Smoking/vaping/tobacco use; individualized intervention offered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Substance use: <input type="checkbox"/> Alcohol: _____ <input type="checkbox"/> Drug: _____ <input type="checkbox"/> Teen pregnancy: _____ <input type="checkbox"/> Other (specify): _____ _____ _____
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STI History

Current Medications

	Screen Date	Negative	Positive	<input type="checkbox"/> No Medications
<input type="checkbox"/> HIV:	_____	<input type="checkbox"/>	<input type="checkbox"/>	Please list: _____ _____ _____
<input type="checkbox"/> Syphilis:	_____	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Gonorrhea:	_____	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Chlamydia:	_____	<input type="checkbox"/>	<input type="checkbox"/>	

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 ten days of the member's first prenatal visit. Please fax each form to 877-353-6913.