

Notification of Pregnancy Form**Fax completed form to (select one):**

Anthem 855-325-5453
 Children's Community Plan 414-266-4726
 GHC of South Central Wisconsin 608-662-4907
 iCare 414-231-1090 Attn: Bao Xiong
 MHS Health WI 866-671-3668
 MercyCare 608-752-3751

Molina 877-708-2117
 My Choice Wisconsin (SSI) 608-210-4050 Attn: HPCM Clinical Team
 My Choice Wisconsin (BC) 414-771-1159
 UnitedHealthcare Community Plan 877-353-6913

Member Information

Last Name: _____ First Name: _____ DOB: _____ ID#: _____

Address: _____ City: _____ Zip: _____ Phone #: _____

Date of Initial Prenatal Visit: _____ Completion date of Pregnancy Form: _____

Current Pregnancy

In PNCC _____

Gravida _____ Para _____ LMP _____ EDC _____ Blood Type _____

Multiple Gestation this pregnancy **Maternal age \leq 16 years** Maternal age \geq 35 years of age

Previous Pregnancies (Check all that apply)

Hx of Placenta Pre Multiple Gestations previous pregnancy
Hx of Post Partum Depression **Preterm Labor/Delivery** **Hx of SAB/TAB/Fetal Demise**
Previous C-Section **Week of delivery** _____ **Week of demise** _____

Medical History (Check all that apply)

Cardiac Disease Clotting Disorders Hypertension or PIH (Current/Past)
Respiratory Conditions **Behavioral Health Concerns** Incompetent cervix (Current/Past)
HIV Status STD (Current/Past) Neurologic Disorders (Current/Past)
Sickle Cell Anemia **Diabetes/Gestational Diabetes (Current/Past)**

Psycho/Social Issues (check all that apply)

Drug Abuse(Current/Past) Alcohol Abuse (Current/Past) Smoker (Current/Past)
Domestic Abuse (Current/Past) Housing Issues Lack of Support System

Prenatal Care and Nutrition (Check all that apply)

Missed several medical appointments Currently Enrolled in WIC

Description of above or other unlisted conditions: _____

List of Medications: _____

Provider Information

Provider Signature _____

Provider Printed Name _____

Provider Address _____

Provider Phone # _____

Delivery Hospital _____

Provider Fax # _____