## Notification of Pregnancy Form





MS-PNOP-0445

## \*Required Field

**MEMBER INFO** 

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The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. Please complete clearly in black ink and fax to: 1-866-681-5125.

Member ID*	DOB* (mmddyyyy)	
Last Name*	First Name*	
Mailing Address		
City	State Zip	
Home Phone – –	Cell Phone – –	
Email Address		
Primary Insurance (for mom or baby) other than Medicaid	id? Yes No	
Due Date* (mmddyyyy)	Date of last Chlamydia Screening	
Date of first Prenatal Visit (mmddyyyy)	(mmddyyyy): Date of last Pap Smear	
Race/Ethnicity (Mark each box with a thick X)	(mmddyyyy):	
White Black/African American Hispanic/Latir	ina American Indian/Native American	
Asian Hawaiian/Pacific Islander Other	Please specify	
Preferred Language (if other than English)		
Number of Full Term Deliveries	Number of Stillbirths	
Number of Preterm Deliveries	Enrolled in WIC? Yes No	
Number of Miscarriages/Abortions	Planning to breastfeed? Yes No	
Height Pre-Pregnancy Weight	Pre-Pregnancy BMI	
PREGNANCY RISK ASSESSMENT		
·	If there are no known risk factors, please fill in here	
	Current Pregnancy (place a thick X for all that apply):	
Previous Preterm (<37 weeks) delivery?	Preterm labor this pregnancy?	_
If yes, was the delivery spontaneous?		
Currently on 17P?	Vaginal bleeding after 14 weeks?	
Recent delivery (within past 12 months)?	Shortened Cervix < 23 weeks this pregnancy?	
(within past 6 months)?	Length	
Previous C-Section?	Current gestational diabetes?	
Previous severe preeclampsia?	Current preeclampsia?	
Diabetes (prior to pregnancy)?	Current oligohydramnios?	_
Sickle Cell?	Twins? Triplets? Discordant?	
Asthma?	Current fetal growth restriction?	
Worse symptoms during pregnancy?	Current congenital anomalies?	

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Last Name*	
First Name*	DOB* (mmddyyyy)
History (place a thick X for all that apply):	Current Pregnancy (place a thick X for all that apply):
High Blood Pressure (prior to pregnancy)?	BMI <20 or poor weight gain this pregnancy?
Well controlled?	UTI/Pyelo/Bacteriuria this pregnancy?
Previous neonatal death or stillborn?	Current severe hyperemesis?
Associated with maternal health condition?	Current mental health concerns?
HIV positive? HIV negative? Testing refused?	List
AIDS?	Current STD? List
Seizure disorder?	Current tobacco use? Amount
Seizure within the last 6 months?	Current alcohol use? Amount
Previous alcohol or drug abuse?	Current street drug use?
Other Significant Risk Factors Yes No Please list	below.
Date (mmddyyyy)  OB Provider Name*  TIN/ID Number*  Phone Number Mailing Address	mber
City	State Zip Code

If you would like your patient to receive a free 3 month supply of prenatal vitamins, please complete the Prenatal Vitamin Form. For any questions regarding this form or the Start Smart program, please call 1-866-912-6285.

