Notification of Pregnancy Form

Start Smart for Your Baby®

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 INFO

*Required Field

Member ID*

Last Name* First Name*

DOB* (mmddyyyy) Mailing Address

City State Zip

Home Phone – – Cell Phone – –

Email Address

Primary Insurance (for mom or baby) other that Medicaid? Yes O No O

Due Date* (mmddyyyy) Date of last Chlamydia Screening: (mmddyyyy)

Date of first Prenatal Visit (mmddyyyy) Date of last Pap Smear (mmddyyyy)

Race/Ethnicity (fill in all that apply) White O Black/African American O Hispanic/Latina O American Indian/Native American O

Asian O Hawaiian/Pacific Islander O Other O Please specify

Preferred Language (if other than English)

Number of Full Term Deliveries Number of Stillbirths Height ' "

Number of Preterm Deliveries Enrolled in WIC? Yes O No O Pre-Pregnancy Weight

Number of Miscarriages/Abortions Planning to breastfeed? Yes O No O Pre-Pregnancy BMI

Pregnancy risk assessment

Are any of the following risk factors present?* If there are no known risk factors, please fill in here O

History (fill in all that apply):

Previous Preterm (<37 weeks) delivery? O
If yes, was the delivery spontaneous? O
Currently on 17P? O
Recent delivery (within past 12 months)? O
(within past 6 months)? O
Previous C-Section? O
Previous severe preeclampsia? O
Diabetes (prior to pregnancy)? O
Sickle Cell? O
Asthma? O
Worse symptoms during pregnancy? O
High Blood Pressure (prior to pregnancy)? O
Well controlled? O
Previous neonatal death or stillborn? O
Associated with maternal health condition? O
HIV positive? O HIV negative? O Testing refused? O
AIDS? O
Seizure disorder? O
Seizure within the last 6 months? O
Previous alcohol or drug abuse? O

Current Pregnancy (fill in all that apply):

Preterm labor this pregnancy? O
Current placenta previa? O
Vaginal bleeding after 14 weeks? O
Shortened Cervix < 23 weeks this pregnancy? O
Length
Current gestational diabetes? O
Current preeclampsia? O
Current oligohydramnios? O
Twins? O Triplets? O Discordant? O
Current fetal growth restriction? O
Current congenital anomalies? O
BMI <20 or poor weight gain this pregnancy? O
UTI/Pyelo/Bacteriuria this pregnancy? O
Current severe hyperemesis? O
Current mental health concerns? O
List
Current STD? O List
Current tobacco use? O Amount
Current alcohol use? O Amount
Current street drug use? O

For any questions regarding this form or the Start Smart program, please call 1-855-694-HOME (4663).

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Last Name* First Name*

DOB* (mmddyyyy)

Any social needs? Yes O No O Please list below

Other Significant Risk Factors Yes O No O Please list below

Date (mmddyyyy)

OB Provider Name*

TIN/ID Number* **Phone Number** – –

Mailing Address

City **State** **Zip Code**

Approved September 5, 2012