



Prenatal Risk Assessment Form

The earliest possible completion of this form allows the Managed Care Plans to use their resources to help you and your patient achieve a healthy pregnancy outcome.

(Please print or type)

Patient/Member Name:		Provider Name:	Expected Date of Delivery (EDD): (mo/day/yr)
Member ID #:	Patient DOB:	Provider Telephone:	Date of First Prenatal Visit:
Patient Address:		Provider Billing Number: NPI (National Provider Identifier):	Gravida : Para: Has a social service or community outreach referral (such as WIC) been made by your office? Date: Agency:
Patient Telephone: Cell Phone:		Please complete and fax to 1-xxx-xxx-xxxx or mail to _____.	
Other Insurance?: _____			

Factors I (One or more place patient at risk):

History of: <input type="checkbox"/> Cerclage placement/cervical insufficiency <input type="checkbox"/> Cone biopsy, LEEP or laser (follow to 24 wks) <input type="checkbox"/> Elevated BP \leq 32 wks gestation <input type="checkbox"/> Insulin dependent gestational diabetes <input type="checkbox"/> Low birth weight infant (< 2500 gms) <input type="checkbox"/> Placental abruption	Preterm delivery <input type="checkbox"/> Preterm labor (contractions with cervical change) <input type="checkbox"/> Preterm premature rupture of membranes (PPROM) <input type="checkbox"/> Second or third trimester loss <input type="checkbox"/> Two or more spontaneous or elective first trimester losses <input type="checkbox"/> Uterine surgery/Prior C-Sec
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Current pregnancy: <input type="checkbox"/> Abdominal surgery after 18 wks (follow for six wks after surgery) <input type="checkbox"/> Abnormal first or second trimester screen <input type="checkbox"/> Abnormal karyotype (Trisomy 13, 18, 21, etc.) <input type="checkbox"/> Age extreme (under 16 years or over 40 years) <input type="checkbox"/> Asthma, on daily medication <input type="checkbox"/> Autoimmune disorders (e.g., APS, ITP, SLE) <input type="checkbox"/> Bleeding after 20 wks gestation <input type="checkbox"/> Cardiac disease or condition <input type="checkbox"/> Cerclage placement/cervical incompetence <input type="checkbox"/> Diabetes: IDDM or GDM on oral med or insulin <input type="checkbox"/> Domestic violence <input type="checkbox"/> Drug or alcohol use during pregnancy <input type="checkbox"/> Eating disorder (anorexia, bulimia or other) <input type="checkbox"/> Fetal anomaly <input type="checkbox"/> Fetal growth restriction (FGR or IUGR) <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hyperemesis with hospitalization or homecare services <input type="checkbox"/> Hypertension, chronic <input type="checkbox"/> Hypertension, gestational <input type="checkbox"/> Hypo/hyperthyroid (unstable lab values) <input type="checkbox"/> Isoimmunization (Rh, ABO or other incompatibility)	<input type="checkbox"/> Morbid obesity (pre-pregnancy BMI 40 or above) <input type="checkbox"/> Multiple gestation- include number of fetuses _____ <input type="checkbox"/> Oligohydramnios/Polyhydramnios <input type="checkbox"/> Placental abruption <input type="checkbox"/> Placenta previa <input type="checkbox"/> Pre-eclampsia (High BP with proteinuria, edema or both) <input type="checkbox"/> Preterm labor (contractions with cervical change) or positive fetal fibronectin <input type="checkbox"/> PPRM with anticipated discharge to home <input type="checkbox"/> Psychological disorder (on meds or in therapy) <input type="checkbox"/> Pyelonephritis <input type="checkbox"/> Recurrent UTIs, two or more since pregnancy began <input type="checkbox"/> Seizure disorder (on medication) <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Thrombophilia (inherited or acquired) <input type="checkbox"/> Tobacco use during pregnancy <input type="checkbox"/> Trauma threatening pregnancy <input type="checkbox"/> Underweight (pre-pregnancy BMI less than 20 or pre-pregnancy weight 100 lbs or less) <input type="checkbox"/> Uterine anomaly <input type="checkbox"/> Venous thromboembolism (VTE) (deep vein thrombosis/pulmonary embolism)
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Factors II (Two or more place patient at risk):

<input type="checkbox"/> Age extreme (<18 years or >35 years) <input type="checkbox"/> Anemia (hgb < 10, hct < 30) <input type="checkbox"/> Asthma, not using daily medication <input type="checkbox"/> Bacterial vaginosis / GBS < 34 wks gestation <input type="checkbox"/> Grand multipara (\geq 5 pregnancies of \geq 20 wks) <input type="checkbox"/> History of substance abuse <input type="checkbox"/> Hypo / hyperthyroid (stable lab values)	<input type="checkbox"/> Late prenatal care (after 20 wks gestation) <input type="checkbox"/> Obesity (pre-pregnancy BMI \geq 30 and <40) <input type="checkbox"/> Psychological disorder (not on meds or in therapy) <input type="checkbox"/> Recent delivery (less than one year between delivery and conception of Next pregnancy) <input type="checkbox"/> Weight loss (continuing after 14 wks gestation)
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At Risk of Poor Pregnancy Outcome

Obstetrical History: <input type="checkbox"/> Congenital anomaly, major	<input type="checkbox"/> Infant death- stillborn, neonatal, post-neonatal
Current Pregnancy	
<input type="checkbox"/> Anesthesia-related allergies <input type="checkbox"/> Epilepsy or on anticonvulsant <input type="checkbox"/> Familial genetic disorder, confirmed <input type="checkbox"/> Group B Streptococcal disease <input type="checkbox"/> Height, less than five feet <input type="checkbox"/> Hepatitis or chronic liver disease	<input type="checkbox"/> HIV/ARC/AIDS <input type="checkbox"/> Illiteracy - Health Illiteracy <input type="checkbox"/> Language barrier <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Other (please specify) _____

Form Completed By: _____	Date: _____
Physician's Signature: _____	Date: _____