Notification of Pregnancy

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:**

Louisiana Healthcare Connections 1-866-681-5125 ○ **Healthy Blue 1-800-964-3627** ○
Aetna Better Health 1-888-858-3875 ○ **AmeriHealth Caritas 1-888-877-5925** ○
United Healthcare 1-877-353-6913 ○

Member Info

*required field

Member ID* _____

Last Name _____ First Name _____

DOB (mmddyyyy) _____ Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Due Date* (mmddyyyy) _____ Preferred Language (if other than English) _____

Date of first Prenatal Visit (mmddyyyy) _____ Pre-Pregnancy Weight _____

Race/Ethnicity (fill in all that apply) White ○ Black/African American ○ Hispanic/Latina ○ American Indian/Native American ○
Asian ○ Hawaiian/Pacific Islander ○ Other ○ Please specify _____

Number of Full Term Deliveries _____ Number of Stillbirths _____

Number of Pre-Term Deliveries _____ Number of Miscarriages/Abortions _____

Pregnancy risk assessment

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

History (fill in all that apply):

Previous Pre-Term (<37 weeks) delivery?..... ○
If yes, was the delivery spontaneous?..... ○
Is the member a candidate for progesterone injections?... ○
Recent delivery (within past 12 months)?..... ○
Previous C-Section?..... ○
Diabetes (prior to pregnancy)?..... ○
Sickle Cell?..... ○
Asthma?..... ○
High Blood Pressure (prior to pregnancy)?..... ○
HIV positive?..... ○
Seizure disorder?..... ○
Seizure within the last 6 months?..... ○
Previous alcohol or drug abuse?..... ○

Current Pregnancy (fill in all that apply):

Pre-Term labor this pregnancy?..... ○
Shortened Cervix < 23 weeks this pregnancy?..... ○
Length _____ ○
Cervical Cerclage placement?..... ○
Twins? ○ Triplets? ○ Discordant? ○
Current severe hyperemesis?..... ○
Current mental health concerns?..... ○
List
Current STD? ○ List _____
Current tobacco use? ○ Amount _____
Current alcohol use? ○ Amount _____
Current street drug use?..... ○

Date (mmddyyyy) _____

OB Provider name* _____

TIN/ID number* _____ **Phone number** _____

Mailing Address _____

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