

PREGNANCY RISK SCREENING AND NOTIFICATION

Name: First _____ Middle _____ Last _____

DCN or Temp #: _____ **Birthdate:** month _____ day _____ year _____

Address: Street _____ Apt _____ City _____ State _____ Zip Code _____

Telephone: () _____ **Alternative Telephone:** () _____ **County:** _____

Current Martial Status: Single__ Married__ Widowed__ Divorced__ Separated__

Ethnicity: Hispanic__ Non-Hispanic__

Race: Black__ White__ Am. Indian__ Hawaiian Pacific Islander__ Asian__ Other _____

English as a second language: Yes__ No__ **Language(s) Spoken** _____

Interpreter needed Yes__ No__ **Deaf/Hard of Hearing:** Yes__ No__

Interpreter needed: Yes__ No__

Gravida _____ **Para** _____ **Aborta** _____ **Anticipated Delivery:** Vaginal__ C-Section__ VBAC__

LMP: month__ day__ year__ **EDC:** month__ day__ year__ **1st Prenatal Visit:** month__ day__ year__

Anticipated Delivering Hospital: _____ **Anticipated Delivering City:** _____

Check all risk factors below that apply/Circle if current/history-client/partner

(Any risk checked qualifies client for prenatal case management)

- | | |
|---|---|
| <p>___1. Pre-pregnant weight <100 lb</p> <p>___2. Pre-pregnant weight >200 lbs</p> <p>___3. Diabetes__ Gestational__ Type 1__ Type 2</p> <p>___4. Vaginosis-history/current Syphilis-history/current</p> <p>___5. Gonorrhea-history/current Chlamydia-history/current</p> <p>___6. HIV</p> <p>___7. Hepatitis B-history/current</p> <p>___8. Hepatitis C-history/current</p> <p>___9. Hypertension, Hx of 140/90 or ></p> <p>___10. Pregnancy Induced Hypertension</p> <p>___11. Incompetent cervix or cerclage</p> <p>___12. Interconceptual Spacing < 1 year</p> <p>___12. Multiple gestation- history/current</p> | <p>___13. Preterm Labor – history/current</p> <p>___14. Previous C-section</p> <p>___15. Previous Fetal Death/Stillborn (20 wks or >)</p> <p>___16. Previous Infant Death</p> <p>___17. Prior Low Birthweight infant(<2500 gms)</p> <p>___18. Smoking-history/current</p> <p>___19. Domestic Violence-history/current</p> <p>___20. Alcohol use-client/partner</p> <p>___21. Drug use-client/partner</p> <p>___22. Mental Illness-history/current</p> <p>___23. Lack of family/friends who provide support</p> <p>___24. Homeless</p> <p>___25. Other (must be prior authorized by DHSS)
(Fee for Service Providers only)</p> |
|---|---|

Other medical or social concerns _____

Did the provider counsel on smoking? Yes__ No__	Was client directed to smoking cessation resource? Yes__ No__
Did the provider counsel on alcohol use? Yes__ No__	Was client directed to alcohol/substance abuse resource? Yes__ No__
Did the provider counsel on substance use? Yes__ No__	Was client directed to domestic violence resource? Yes__ No__

Enrolled in WIC @ time of risk screening? Yes__ No__ Was client directed to WIC? Yes__ No__

Blood test for lead level performed? Yes__ No__

Authorization Number: _____

Notify Health Plan of new medical risks identified during pregnancy _____

Provider Name: _____

Provider Phone: _____

Provider Fax #: _____

Performing Provider #: _____

Name of person completing form: _____ Title: _____ Date: _____

Providers must notify Missouri Care of all members receiving prenatal care by completing and faxing this form within two (2) business days of the initial prenatal visit. Once the completed form is received by Missouri Care an authorization number for global obstetrical care will be faxed to the provider. The authorization number is required for your reimbursement.

Fax to Missouri Care Health Plan @ (866) 946-2052