

Member Information

Member ID Number: _____

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):	Telephone Number:
Address:		City, State, Zip Code:		
Email:		Date of initial prenatal visit/Diagnosis date:	Completion date of pregnancy form:	

Pregnancy Information and History

LMP	Gestational age at first visit	EDC	Gravida	Para	Pre-term	Living	Abortions
_____	_____	_____	_____	_____	_____	_____	Spontaneous: _____ Induced: _____

Risk Factors (past or current)

No Risk Factors

Diabetes/GDM/LGA baby

DVT/PT

Eclampsia/Pre-eclampsia

Fetal congenital anomaly or disorder

Fetal death

Second trimester Third trimester

Hypertension/GHTN

Incompetent cervix

IUGR/SGA baby

Late and/or inconsistent prenatal care

Low birth weight < 2500 grams

Multiple gestation

Placenta abnormalities

Abruption Previa

Premature ROM

Pre-term (specify gestational age)

Delivery: _____

Labor: _____

Renal Disease

Sickle cell disease/trait

Abnormal ultrasound: _____

Uterine abnormality: _____

Other: _____

Active Medical Conditions

None

Advanced maternal age

Asthma

Auto-immune disease(s)

BMI (low or high): _____

Hepatitis

HIV

Seizure disorder: _____

Thyroid disease - treated?

Yes No

Other (specify): _____

Social, Economic and Lifestyle Factors

No Risk Factors

Behavioral health condition

Domestic violence

Housing issues

Identified social, economic and lifestyle

Intellectual impairment

Lack of support system

Literacy issues

Mental/physical/sexual abuse

(current or history of): _____

Postpartum depression

Smoking/tobacco use; individualized intervention offered?

Yes No

Substance abuse:

Alcohol: _____

Drug abuse: _____

Teen pregnancy: _____

Other (specify): _____

STI History

	Screen Date	Negative	Positive
<input type="checkbox"/> HIV:	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Syphilis:	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gonorrhea:	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chlamydia:	_____	<input type="checkbox"/>	<input type="checkbox"/>

Current Medications

No Medications

Please list: _____

Provider Information

Provider Name:	Tax ID Number:	Phone Number:	Fax Number:	Delivery Hospital:
Address:		City, State, Zip Code:		

Provider (MD/DO/APRN/PA): _____ Date: _____

Please fax form to the member's plan:

Nebraska Total Care

Healthy Blue

UnitedHealthcare Community Plan of Nebraska

844-843-3890

844-483-4918

877-353-6913