



Prenatal Risk Assessment Form

(Please print or type)

Patient/Member Name:		Provider Name:	Expected Date of Delivery (EDD): (mo/day/yr)
Member ID #:	Patient Age:	Provider Telephone:	Date of First Prenatal Visit:
Patient Address:		Provider Billing Number: NPI (National Provider Identifier):	Social Service Referral? Date: Agency:
Patient Telephone: Cell Phone:		Please complete and fax to 1-866-573-0013 (this is for PRAF forms only) or mail to CareSource, Attn: Case Management, P.O. Box 8738, Dayton, OH 45401-8738. Forms must be received within four weeks of date of service.	

At Risk of Pre-term Birth

Please check all that apply. If at least one factor is checked, patient is at risk of pre-term birth – V23.8

Obstetrical History

- | | | |
|---|---|---|
| <input type="checkbox"/> 1. Abortion, elective | <input type="checkbox"/> 4. Eclampsia or severe pre-eclampsia | <input type="checkbox"/> 7. Pre-term delivery/labor |
| <input type="checkbox"/> 2. Abortion, spontaneous | <input type="checkbox"/> 5. Incompetent cervix | <input type="checkbox"/> 8. Other (please specify): _____ |
| <input type="checkbox"/> 3. Cone biopsy | <input type="checkbox"/> 6. Low birth weight, less than 2500g | |

Current Pregnancy

- | | |
|---|---|
| <input type="checkbox"/> 9. Abdominal surgery | <input type="checkbox"/> 29. Malignancy or leukemia |
| <input type="checkbox"/> 10. Age, less than 21 years | <input type="checkbox"/> 30. Missed prenatal appointments |
| <input type="checkbox"/> 11. Age, 35 years or older | <input type="checkbox"/> 31. Multiple gestation |
| <input type="checkbox"/> 12. Alcohol Abuse | <input type="checkbox"/> 32. Oligohydramnios |
| <input type="checkbox"/> 13. Anemia, less than 11 hgb or less than 33% hct | <input type="checkbox"/> 33. Placenta previa |
| <input type="checkbox"/> 14. Asthma, on medication | <input type="checkbox"/> 34. Pneumonia |
| <input type="checkbox"/> 15. Bleeding, if significant after 12 weeks | <input type="checkbox"/> 35. Polyhydramnios |
| <input type="checkbox"/> 16. Cervix dilated, more than 1.5 cm before 29 weeks | <input type="checkbox"/> 36. Poor nutrition |
| <input type="checkbox"/> 17. Cervix effaced, more than 50% before 29 weeks | <input type="checkbox"/> 37. Prenatal care noncompliance, most recent pregnancy |
| <input type="checkbox"/> 18. Chronic bronchitis | <input type="checkbox"/> 38. Pre-term labor |
| <input type="checkbox"/> 19. Diabetes, insulin dependent | <input type="checkbox"/> 39. PROM, confirmed |
| <input type="checkbox"/> 20. Diabetes, non-insulin dependent | <input type="checkbox"/> 40. Sickle cell or other hemoglobinopathy |
| <input type="checkbox"/> 21. Domestic Violence | <input type="checkbox"/> 41. Smoking |
| <input type="checkbox"/> 22. Drug Abuse | <input type="checkbox"/> 42. Trauma |
| <input type="checkbox"/> 23. Eclampsia or pre-eclampsia | <input type="checkbox"/> 43. Underweight, less than 15% weight for height |
| <input type="checkbox"/> 24. Heart disease | <input type="checkbox"/> 44. Uterine anomaly or fibroids |
| <input type="checkbox"/> 25. Hypertension | <input type="checkbox"/> 45. UTI |
| <input type="checkbox"/> 26. Irritable uterus | <input type="checkbox"/> 46. Weight loss |
| <input type="checkbox"/> 27. Kidney disease | <input type="checkbox"/> 47. Other (please specify): _____ |
| <input type="checkbox"/> 28. Late initial visit, after 14 weeks of pregnancy | |

At Risk of Poor Pregnancy Outcome

Please check all that apply. If at least one factor is checked, patient is at risk of poor pregnancy outcome – V23.9

Obstetrical History:

- | | |
|--|--|
| <input type="checkbox"/> 48. Congenital anomaly, major | <input type="checkbox"/> 49. Infant death - stillborn, neonatal, post-neonatal |
|--|--|

Current Pregnancy

- | | |
|--|--|
| <input type="checkbox"/> 50. Anesthesia-related allergies | <input type="checkbox"/> 61. HIV/ARC/AIDS |
| <input type="checkbox"/> 51. Behavioral Health condition | <input type="checkbox"/> 62. Illiteracy |
| <input type="checkbox"/> 52. Deep venous thrombosis | <input type="checkbox"/> 63. Isoimmunization associated with fetal disease |
| <input type="checkbox"/> 53. Diabetes, gestational, diet-controlled | <input type="checkbox"/> 64. Language barrier |
| <input type="checkbox"/> 54. Diabetes, gestational, on medication | <input type="checkbox"/> 65. Mental Retardation |
| <input type="checkbox"/> 55. Epilepsy or on anticonvulsant | <input type="checkbox"/> 66. Obesity, more than 20% weight for height |
| <input type="checkbox"/> 56. Familial genetic disorder, confirmed | <input type="checkbox"/> 67. Prior C-section and/or previous uterine scar |
| <input type="checkbox"/> 57. Grand multipara, more than five of 20 weeks or more | <input type="checkbox"/> 68. Recent delivery, less than one year |
| <input type="checkbox"/> 58. Group B Streptococcal disease | <input type="checkbox"/> 69. Sexually transmitted disease, any |
| <input type="checkbox"/> 59. Height, less than five feet | <input type="checkbox"/> 70. Thyroid disease, confirmed |
| <input type="checkbox"/> 60. Hepatitis or chronic liver disease | <input type="checkbox"/> 71. Other (please specify): _____ |

Provider's Signature: _____

Date: _____