

Pregnancy Risk Assessment Form – Provider Screening

PROVIDER: PLEASE FAX COMPLETED FORM TO (937) 487-1157 or email to MaternalChildHealth@CareSource.com

Practice Name: _____ Phone Number: _____ Date ___/___/_____
 Member First name: _____ MI _____ Last name: _____ DOB: ___/___/_____
 EDC: ___/___/____ By what criteria: LMP 1st trimester U/S 2nd trimester U/S Other: _____
 Height: _____ Pre-pregnancy weight: _____ Gravidity: _____ Parity: _____ CareSource ID#: _____

CURRENT PREGNANCY

- *Multifetal gestation**
 - *Fetal complications:**
 - Fetal anomaly
 - Fetal chromosomal abnormality
 - Intrauterine growth restriction (IUGR)
 - Oligohydramnios
 - Polyhydramnios
 - Other: _____
 - *Chronic condition which may complicate pregnancy:**
 - Asthma
 - Diabetes
 - HIV
 - Hypertension
 - Mental illness
 - Renal disease
 - Seizure disorder
 - Systemic lupus erythematosus
 - Other(s): _____
 - *Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)**
 - *Late entry into prenatal care (>14 weeks)**
 - *Hospital utilization in the antepartum period**
 - *Missed 2+ prenatal appointments**
 - Cervical insufficiency
 - Gestational diabetes
 - Vaginal bleeding in 2nd trimester
 - Hypertensive disorders of pregnancy
 - Eclampsia
 - Gestational hypertension
 - HELLP syndrome
 - Preeclampsia
 - Short interpregnancy interval (<12 months between last live birth and current pregnancy)
 - Current sexually transmitted infection
 - Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
 - Communication barriers:
 - Disability
 - Literacy
- Explain: _____
 Non-English speaking
 Primary language: _____

Items marked with * will trigger follow-up with a pregnancy case manager

OBSTETRIC HISTORY

- *Preterm birth (<37 completed weeks)**
 Gestational age(s) of previous preterm birth(s):
 _____ weeks, _____ weeks, _____ weeks
- *At least one spontaneous preterm labor and/or rupture of the membranes¹**
¹If this is a singleton gestation, this patient is eligible for 17P treatment.
- *Low birth weight (<2500g)**
- *Very low birth weight (<1500g)**
- Fetal death >20 weeks
- Neonatal death (within first 28 days of life)
- Second trimester pregnancy loss
- Three or more first trimester pregnancy losses
- Cervical insufficiency
- Gestational diabetes
- Postpartum depression
- Hypertensive disorders of pregnancy:
 - Eclampsia
 - Preeclampsia
 - Gestational hypertension
 - HELLP syndrome
- *Provider requests pregnancy care management**
 Reason(s): _____

Provider comments/notes: _____

Name of person completing form: _____ Signature: _____

Pregnancy Risk Self Screening Form

Complete this side of the form and give it to the nurse or doctor. Please answer as honestly as possible so we can provide the best care for you and your baby. The care team will keep this information private.

Name: _____ Date of birth: _____ Today's date: _____
Physical Address: _____ City: _____ ZIP: _____
Mailing Address (if different): _____ City: _____ ZIP: _____
County: _____ Home phone number: _____ Work phone number: _____
Cell phone number: _____ Social Security Number: _____
Race: American-Indian or Alaska Native Asian Black/African-American Pacific Islander/Native Hawaiian
 White Other (specify): _____
Ethnicity: Not Hispanic Cuban Mexican American Puerto Rican Other Hispanic

1. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
 - I wanted to be pregnant sooner.
 - I wanted to be pregnant now.
 - I wanted to be pregnant later.
 - I did not want to be pregnant then or any time in the future.
 - I don't know.
2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? Yes No
3. Are you in a relationship with a person who threatens or physically hurts you? Yes No
4. Has anyone forced you to have sexual activities that made you feel uncomfortable? Yes No
5. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food? Yes No
6. Is your living situation unsafe or unstable? Yes No
7. Which statement best describes your smoking status? Check one answer.
 - A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
 - B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
 - C. I stopped smoking AFTER I found out I was pregnant and am not smoking now.
 - D. I smoke now but have cut down some since I found out I was pregnant.
 - E. I smoke about the same amount now as I did before I found out I was pregnant.
8. Did any of your parents have a problem with alcohol or other drug use? Yes No
9. Do any of your friends have a problem with alcohol or other drug use? Yes No
10. Does your partner have a problem with alcohol or other drug use? Yes No
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?
 Yes No
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?
 Not at all Rarely Sometimes Frequently
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?
 Not at all Rarely Sometimes Frequently

(For Pregnancy Care Management use only) Date risk screening form was received: _____/_____/_____