

Pregnancy Notification Report

All providers must complete this form. It must be submitted to BlueChoice HealthPlan Medicaid within 30 days of assessment.
Please fax to **1-800-551-2410**

SECTION A: Patient Information

Today's Date (MM/DD/YY): _____ ID Card Number/CIN Number: _____ Date of Birth (MM/DD/YY): _____

Last Name: _____ First Name: _____

Street Address: _____ Apt. No.: _____ City: _____ State: _____ ZIP Code: _____

Phone No.: _____ Confidential Pregnancy

LMP: _____ Anticipated Place of Delivery: _____ Due Date (MM/DD/YY): _____

Language Spoken: English Spanish Other: _____

Race: White Black Am Indian Asian Other: _____

SECTION B: OB Provider Information

Last Name: _____ First Name: _____

Street Address: _____ Suite No.: _____ City: _____ State: _____ ZIP Code: _____

Phone No.: _____ Tax ID No.: _____ Provider License No.: _____

SECTION C: Current Medications

List all current medications.

None

Other: _____

SECTION D: Risk Assessment

Medical

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Currently receiving 17-P injections | <input type="checkbox"/> Current placental problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Previous preterm birth (< 5 lbs.) |
| <input type="checkbox"/> Advanced maternal age (>35 years) | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> History of high-risk pregnancy |
| <input type="checkbox"/> History of poor pregnancy outcome | <input type="checkbox"/> Multifetal pregnancies | <input type="checkbox"/> Pregnancy-induced hypertension |
| <input type="checkbox"/> Medications that may affect fetal outcome | <input type="checkbox"/> Teen pregnancy (< 17 years) | |
| <input type="checkbox"/> Other _____ | | |

Substance Abuse

- | | | | |
|--|------------------|---|------------------|
| <input type="checkbox"/> Prescription drugs used | How often? _____ | <input type="checkbox"/> Illegal drugs used | How often? _____ |
| <input type="checkbox"/> Alcohol | How often? _____ | <input type="checkbox"/> Other | How often? _____ |
| <input type="checkbox"/> Tobacco/cigarettes | How often? _____ | | |

Other

List any other medical/psychological problems not included above or other issues which may place the member at risk: _____

SECTION E: Referrals

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> WIC | <input type="checkbox"/> Case management | <input type="checkbox"/> Smoking cessation | <input type="checkbox"/> Glucose monitor with nutrition counseling |
| <input type="checkbox"/> Nutritional counseling | <input type="checkbox"/> Substance abuse treatment | <input type="checkbox"/> Parenting/childbirth classes | |

Provider comments or suggestions: _____

Signature: _____ Date: _____

To be completed by BlueChoice HealthPlan Medicaid:

Date entered into system: _____ Document Control Number: _____