



MATERNITY RISK SCREENING FORM

Member Information:

Member Name (first, middle initial, last): Member's Date of Birth:
Member ID #: Member Phone #:
Estimated Date of Delivery (EDD): Trimester of Pregnancy: 1st 2nd 3rd Date of First Visit:
Last Menstrual Period:

Provider Information:

Provider Name (first, middle initial, last):
Provider ID Number:
Practice Name/ Group:

Please check all that apply:

Table with 2 columns and 8 rows under section A. OBSTETRICAL/MEDICAL. Items include: Advanced maternal age > 35 yrs., Anemia, Cardiac condition, Gestational diabetes/diabetes, Hepatitis, HIV+/AIDS, Hypertension, chronic or pregnancy induced, Multiple gestation (twins, triplets), Periodontal disease, Previous fetal death, Previous preterm birth before 37 weeks, Asthma/Respiratory condition, Sickle cell/Clotting disorders, STD (specify):, 17-P Candidate: Yes No, Other, please specify:

Table with 2 columns and 6 rows under section B. PSYCHOSOCIAL. Items include: Abuse/domestic violence during pregnancy, Anxiety / Depression / Mental Health disorder, Homeless / Unstable housing, Lack of food, Last delivery within 1 year of EDD, Current Methadone Treatment, Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc., Teenager 18 years or younger, Tobacco / Alcohol use, Transportation, Other Social Concerns:

Table with 2 columns and 5 rows under section REFERRALS AND/OR SERVICE PLAN. Items include: Care Coordination, Glucose Monitor w/nutrition counseling, Home Health, Mental Health, Nutritional Counseling, Parenting/Childbirth Classes, Perinatologist/Specialist, Substance Abuse TX, Tobacco Cessation (Rx or Referral given)

PROVIDER SIGNATURE/STAMP _____

DATE _____

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-962-8074 (TTY: 711).