Pregnancy Notification Report

☞ Thank you in advance for completing this form ☜

Please complete all sections and fax within **7 days** of the **first** prenatal visit and/or positive pregnancy test.

Today's Date: ____/____/____

DIRECTIONS FOR COMPLETION OF FORM:

Step 1: Complete all member information.

Step 2: Complete the OB/GYN section with the name of the OB/GYN to whom the member was referred for prenatal care.

Step 3: Fax form to Molina Healthcare of California's Motherhood Matters Program at **1 (562) 499-6105**

Step 4: If you have any questions or need some assistance, please contact us at **1 (877) 665-4628**

STEP 1: MEMBER INFORMATION

Member's Name:	Member ID/CIN:
Address:	City: State: ZIP:
Member DOB: / /	Phone #: ( ) - Alternate Ph.#: ( ) -
Date of Positive Pregnancy Test: / /	Preferred Language:
LMP:	EDC:

High Risk Condition(s) (if known):

CURRENT PREGNANCY

☐ Hypertension ☐ Excessive Nausea & Vomiting
☐ Diabetes ☐ Pre-term labor
☐ Smoking ☐ Multiple Gestation
☐ No problems with Current Pregnancy
Other:_____

PAST PREGNANCY ☐ N/A

☐ Hypertension ☐ Diabetes
☐ Pre-term labor ☐ Pre-term delivery
☐ No problems with Past Pregnancy
☐ Other:_____

STEP 2: OB/GYN INFORMATION

OB/GYN Practitioner's Name:
OB/GYN Practitioner's Phone Number: ( ) -
Date of First Prenatal Appointment: / /
Referring Practitioner: Phone: ( ) -

STEP 3: FAX FORM TO MOLINA HEALTHCARE

Fax to Molina Healthcare of California's Motherhood Matters Program Fax line at **1 (562) 499-6105**

STEP 4: CALL MOLINA WITH QUESTIONS

If you have any questions or need assistance, please contact us at **1 (877) 665-4628**

Thank you for taking such good care of our members!

[Original form to remain in member's chart]