MOLINA® HEALTHCARE

PREGNANCY NOTIFICATION REPORT

Please Fax to 877-708-2117
Attention: Prenatal RN Case Manager

MEMBER INFORMATION

Last Name	First Name	DOB:	ID#:
Address:	City:	Zip:	Phone#:

Date of Initial Prenatal Visit:	Completion date of Pregnancy Report:

CURRENT PREGNANCY

Gravida:	Para:	LMP:	EDC:	Trimester:	Blood Type:

❑ Maternal age ≤ 16 years of age	❑ Maternal age ≥ 35 years of age	❑ Multiple Gestation this pregnancy

PREVIOUS PREGNANCIES (check all that apply)

❑ Multiple Gestation previous pregnancy		❑ Hx of Post Partum Depression
❑ Maternal age ≤ 16 years of age	❑ Hx of Placenta Previa	❑ Multiple Gestation this pregnancy

❑ Hx of SAB/TAB/Fetal Demise Week of Demise Week of Demise_____ Week of Delivery:_____

MEDICAL HISTORY (check all that apply)

❑ Cardiac Disease (Current/Past)	❑ Neurologic Disorders (Current/Past)	❑ HIV Testing (Current/Past)
❑ Sickle Cell Anemia (Current/Past)	❑ Incompetent cervix (Current/Past)	❑ STD (Current/Past)
❑ Clotting Disorders (Current/Past)	❑ Respiratory Conditions (Current/Past)	❑ Mental Illness (Current/Past)

❑ Diabetes/Gestational Diabetes (Current/Past)

PSYCHO/SOCIAL ISSUES (check all that apply)

❑ Drug Abuse (Current/Past)	❑ Alcohol Abuse (Current/Past)	❑ Smoker (Current/Past)
❑ Domestic Abuse (Current/Past)	❑ Housing Issues	❑ Lack of support system

PRENATAL CARE AND NUTRITION (check all that apply)

❑ Currently enrolled in WIC	❑ Alcohol Abuse (Current/Past)	❑ Smoker (Current/Past)

List of Medications:

Description of above or other unlisted conditions:

PROVIDER INFORMATION

Provider Signature	Provider Printed Name
Provider Address	Provider Phone #
Delivery Hospital	Provider Fax#