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#

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