MOLINA HEALTHCARE | Molina Complete Care

Prenatal Notification Form

The earliest possible completion of this form allows Molina Complete Care (MCC) to coordinate care for your patient. Please fax this completed form to MCC at (888) 656-7541.

Member information

Member name:			Member ID #:	
Member DOB:	Primary language:		Member phone:	
Address:				
City:	State:		ZIP:	
Date of positive pregnancy test:	Date of first prenatal visit:		Health screening completion date:	
LMP:	EDC:	Gravida:	Para:	Living:

Current pregnancy risks and/or medical conditions (Please check any that apply)

- ☐ Diabetes
- ☐ Preeclampsia and/or chronic hypertension
- ☐ Pre-term labor
- ☐ Renal disease
- ☐ Heart disease
- ☐ Sickle cell disease
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Placenta previa
- ☐ Twins
- ☐ Seizure disorder
- ☐ Fetal anomaly
- ☐ Late and/or inconsistent prenatal care
- ☐ Homelessness
- ☐ Domestic violence
- ☐ Nutritional risk:_____
- ☐ Psychiatric disorder:_____
- ☐ Substance abuse:_____
- ☐ Tobacco use: _____
- ☐ Alcohol use:_____
- ☐ STD:_____
- ☐ Other risk and/or diagnosis:_____

Medical conditions from previous pregnancies (Please check any conditions that apply)

- ☐ Postpartum depression
- ☐ Hypertension
- ☐ Diabetes
- ☐ Pre-term delivery
- ☐ Previous c-section
- ☐ Incompetent cervix
- ☐ Low birth weight < 2,500 grams
- ☐ Placenta previa
- ☐ Preeclampsia
- ☐ Gestational diabetes
- ☐ Spontaneous abortion or fetal demise
- ☐ PROM or PPROM

Provider information

Provider name:		Provider ID #:	
Phone number:		Fax number:	
Address:	City:	State:	ZIP: