

Prenatal notification form

Please complete all sections and fax to Molina Complete Care at 1-888-656-5098 to expedite case management.

Member information

Member's name:		Member ID #:			
Address:	City:	State:	Zip:		
Member DOB:	Phone:	Primary language:			
Date of positive pregnancy test:		Date of first prenatal visit:			
LMP:	EDC:	Gravida:	Para:	Living:	AB:

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

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fetal anomaly |
| <input type="checkbox"/> Preeclampsia, and/or chronic hypertension | <input type="checkbox"/> Late and/or inconsistent prenatal care |
| <input type="checkbox"/> Preterm labor | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Renal disease | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nutritional risk _____ |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Psychiatric disorder _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Substance abuse _____ |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tobacco use _____ |
| <input type="checkbox"/> Placenta previa | <input type="checkbox"/> Alcohol use _____ |
| <input type="checkbox"/> Twins | <input type="checkbox"/> STD _____ |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Other risk and/or diagnosis _____ |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Postpartum depression | <input type="checkbox"/> Previous c-section | <input type="checkbox"/> Preeclampsia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Incompetent cervix | <input type="checkbox"/> Gestational diabetes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low birth weight <2500 grams | <input type="checkbox"/> Spontaneous abortion or fetal demise |
| <input type="checkbox"/> Preterm delivery | <input type="checkbox"/> Placenta previa | <input type="checkbox"/> PROM or PPROM |

Health screening *(Please add date completed)*

Health screening completion date:

Provider information

Provider name:		Provider ID:	
Phone:		Fax:	
Address:	City:	State:	Zip: