MOLINA HEALTHCARE | Molina Complete Care

Prenatal notification form

Please complete all sections and fax to Molina Complete Care at 1-855-769-2116.

Member information

Member's name: Molina ID #:

Address: City: State: Zip:

Member DOB: Phone: Primary language:

Date of positive pregnancy test: Date of first prenatal visit:

Expected due date:

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

- ☐ Diabetes
- ☐ Preeclampsia and/or chronic hypertension (high blood pressure, swelling, weight gain, protein in urine)
- ☐ Preterm labor
- ☐ Renal disease
- ☐ Heart disease
- ☐ Sickle cell disease
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Placenta previa (a low lying placenta)
- ☐ 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
- ☐ Preterm delivery
- ☐ Previous c-section
- ☐ Cervix began to dilate too soon
- ☐ Low birth weight <2500 grams
- ☐ Placenta previa (low lying placenta)
- ☐ Preeclampsia (high blood pressure, swelling, weight gain, protein in urine)
- ☐ Gestational diabetes
- ☐ Spontaneous abortion or fetal demise
- ☐ Premature rupture of membranes

WIC

Are you receiving WIC benefits?

OB/GYN provider information

Provider name:

Phone: Fax:

Address: City: State: Zip: