Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to:**

Louisiana Healthcare Connections 1-866-681-5125 ○
Aetna Better Health 1-888-858-3875 ○
Healthy Blue 1-800-964-3627 ○
AmeriHealth Caritas 1-888-877-5925 ○
United Healthcare 1-877-353-6913 ○

Member Info ***required field**

Member ID*

Last Name First Name

DOB (mmddyyyy) Mailing Address

City State Zip

Home Phone – – Cell Phone – –

Email Address

Due Date* (mmddyyyy) Preferred Language (if other than English)

Date of first Prenatal Visit (mmddyyyy) Pre-Pregnancy Weight

Race/Ethnicity (fill in all that apply) White ○ Black/African American ○ Hispanic/Latina ○ American Indian/Native American ○
Asian ○ Hawaiian/Pacific Islander ○ Other ○ Please specify

Number of Full Term Deliveries Number of Stillbirths

Number of Pre-Term Deliveries Number of Miscarriages/Abortions

Pregnancy risk assessment

Are any of the following risk factors present?* If there are no known risk factors, Please fill in here ○

History (fill in all that apply):

Previous Pre-Term (<37 weeks) delivery? ○
If yes, was the delivery spontaneous? ○
Is the member a candidate for progesterone injections? ○
Recent delivery (within past 12 months)? ○
Previous C-Section? ○
Diabetes (prior to pregnancy)? ○
Sickle Cell? ○
Asthma? ○
High Blood Pressure (prior to pregnancy)? ○
HIV positive? ○
Seizure disorder? ○
Seizure within the last 6 months? ○
Previous alcohol or drug abuse? ○

Current Pregnancy (fill in all that apply):

Pre-Term labor this pregnancy? ○
Shortened Cervix < 23 weeks this pregnancy? ○
Length ○
Cervical Cerclage placement? ○
Twins? ○ Triplets? ○ Discordant? ○
Current severe hyperemesis? ○
Current mental health concerns? ○
List
Current STD? ○ List
Current tobacco use? ○ Amount
Current alcohol use? ○ Amount
Current street drug use? ○

Date (mmddyyyy)

OB Provider name* Scott P Stripling

TIN/ID number* 204909738 **Phone number** 985 - 893 - 0995

Mailing Address 77 Starbrush Circle

City Covington **State** La **Zip Code** 70433

Patient Addressograph

DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTH DATE MONTH DAY YEAR	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS
OCCUPATION			EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
LANGUAGE				INSURANCE CARRIER/MEDICAID #
HUSBAND/DOMESTIC PARTNER			PHONE	POLICY #
FATHER OF BABY			PHONE	EMERGENCY CONTACT PHONE

TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED	AB. SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENSES MONTHLY ☐ YES ☐ NO FREQUENCY: Q _____ DAYS MENARCHE _____ (AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION PRIOR MENSES _____ DATE ON BCP AT CONCEPT ☐ YES ☐ NO hCG + ___/___/___
☐ FINAL _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES		
2. HYPERTENSION		
3. HEART DISEASE		
4. AUTOIMMUNE DISORDER		
5. KIDNEY DISEASE/UTI		
6. NEUROLOGIC/EPILEPSY		
7. PSYCHIATRIC		
8. DEPRESSION/POSTPARTUM DEPRESSION		
9. HEPATITIS/LIVER DISEASE		
10. VARICOSITIES/PHLEBITIS		
11. THYROID DYSFUNCTION		
12. TRAUMA/VIOLENCE		
13. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE
14. TOBACCO			
15. ALCOHOL			
16. ILLICIT/RECREATIONAL DRUGS			

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
17. D (Rh) SENSITIZED		
18. PULMONARY (TB, ASTHMA)		
19. SEASONAL ALLERGIES		
20. DRUG/LATEX ALLERGIES/ REACTIONS		
21. BREAST		
22. GYN SURGERY		
23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
24. ANESTHETIC COMPLICATIONS		
25. HISTORY OF ABNORMAL PAP		
26. UTERINE ANOMALY/DES		
27. INFERTILITY		
28. RELEVANT FAMILY HISTORY		
29. OTHER		

COMMENTS _____

ACOG ANTEPARTUM RECORD (FORM A)

Version 5. Copyright © 2003 The American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920 AA128 1 2 3 4 5 / 7 6 5 4 3

Patient Addressograph

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS AS OF ESTIMATED DATE OF DELIVERY			12. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND, MCV < 80			13. MENTAL RETARDATION/AUTISM		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG. TYPE 1 DIABETES, PKU)		
6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH CANADIAN)			16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
7. CANAVAN DISEASE			17. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS					
10. MUSCULAR DYSTROPHY			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
11. CYSTIC FIBROSIS			19. ANY OTHER		

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILIS		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES					
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			5. OTHER (See Comments)		

COMMENTS _____

_____ INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION

DATE ____/____/____ HEIGHT _____ BP_____

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. FUNDI	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. TEETH	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	_____ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	_____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals) _____

_____ EXAM BY _____

ACOG ANTEPARTUM RECORD (FORM B)