OBSTETRIC NOTIFICATION/RISK. ASSESSMENT FORM

Date Rec'd	Product	Reference #

Please complete initial assessment at member's 1st prenatal visit or by the end of the first trimester and/or when insurance coverage changes. When completed, submit via mail or fax to Community Health Network Of Connecticut at 203-265-3830.

Patient Name:________________________, ____________________ **Member ID#:** ________________________**DOB:**__________
Last First

Patient Address: ____ **City:** ____________________ **State:** _________ **Zip:** ___________

Patient Phone: ____-_________ **Primary Language:** ___________**Race:**______ **Gravida:** ______**Para:**_______**AB:**______**LC:**______

EDC: ____________ **LMP:** ______________ **1st Prenatal Visit DATE:** _______________ **1st Visit under Plan:** ___________________

Provider: ______________________________, _______________________ **Plan Provider ID Number:** ________________________
Last First

Office Phone: _____-______-___________ **Office Fax:** _____-_____-_______________ **Contact Person:** ______________________

Hospital for delivery: ________________________________ **Hospital ID#:** __________________ **Other Insurance:** ❑ **YES** ❑ **NO**

HIV Test/Info Offered:	❑ YES	❑ NO, Reason_______________________	❑ Pt Declined	❑ Will offer at a future appt.
WIC Referral Made:	❑ YES	❑ NO, Reason_____________________	❑ Pt Declined	❑ Will offer at a future appt.

Please identify all risks that apply in this pregnancy or previous pregnancy	**Circle if Yes or No**			
❑ **Check here if no risk factors**				
RISK FACTORS (To Be Completed by Clinician)	**Early Risk Assessment**		**History**	
I. Demographic & Psycho/Social				
• Age extreme <18 or >35	Y	N		
• Depression / Psychosocial disorder	Y	N	Y	N
• Obesity	Y	N	Y	N
• Smoker	Y	N	Y	N
• Substance Abuse (Alcohol / Drugs)	Y	N	Y	N
• Transportation Issues	Y	N	Y	N
• Trauma / Violence/ Homeless	Y	N	Y	N
II. OB/Gynecological				
• Hyperemesis (Severe vomiting, weight loss, ketosis etc.)	Y	N	Y	N
• Cervix Incompetent / Short (<2.5cm) / Cerclage	Y	N	Y	N
• Multiple Gestation 2, 3, 4 , 5 or other	Y	N	Y	N
• Fetal Reduction	Y	N	Y	N
• Preterm Labor	Y	N	Y	N
• Preterm Birth	Y	N	Y	N
• Gestational Diabetes/ Diabetes Mellitus	Y	N	Y	N
• Pre-eclampsia/Eclampsia, Pregnancy Induced Hypertension, Chronic Hypertension	Y	N	Y	N
• Previous poor pregnancy outcome (i.e.LBW, Fetal Death, Placenta Previa, NICU stay &/or other serious risk)	Y	N	Y	N

III. Other Identified Risks, including medical conditions, NOT LISTED ABOVE (Describe here):

IV. Prescription Medications:

V. Please check here if you wish a Case Manager to contact you about this patient. ☐

Clinician's Signature ____ Date :_________________

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