

Obstetrical Authorization & Initial Assessment

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Submission Date:

Health Plan:

Member Information

First Name MI Last Name

Member ID or MA Recipient No. Date of Birth (MM/DD/YYYY) Age Home Phone

Provider Name:

NPI or Provider Number:

Phone Number: Fax Number:

Alternate Phone 1st Prenatal Visit (MM/DD/YYYY)

Primary Language **NOT** English Language Spoken (if not English) EDC (MM/DD/YYYY) BMI Gestational Age (weeks) Gravida Para TAB Live Births

Hospital/Birthing Center for Delivery

HUH Providence UMC WHC GWUH Other: Specify:

Past OB Complications/Current Risk Factors

HIV screening date (MM/DD/YYYY): _____ Not Applicable - HIV+

Check all that apply (P=Past Pregnancy C=Current Pregnancy)

- | P | C | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 17 - P Administration |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Placenta |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia Hb <10 |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding: 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cervical cerclage |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic hypertension, pregestational |
| <input type="checkbox"/> | <input type="checkbox"/> | Clotting disorder: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental visit >6 mos? |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/Mental Health |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, pregestational |
| <input type="checkbox"/> | <input type="checkbox"/> | Disability: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ectopic pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> | Elective Delivery <39 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | Fetal loss: 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Gestational diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis: _____ |

- | P | C | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Incompetent cervix |
| <input type="checkbox"/> | <input type="checkbox"/> | Infant or Child death |
| <input type="checkbox"/> | <input type="checkbox"/> | Late/missed prenatal care |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple gestation |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral Problems: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Preeclampsia/Eclampsia |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy induced hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature ROM |
| <input type="checkbox"/> | <input type="checkbox"/> | Preterm delivery |
| <input type="checkbox"/> | <input type="checkbox"/> | Preterm labor: <32W <input type="checkbox"/> 32-36W <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous C-Section |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous delivery within 1 year |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous LBW (<2,500 gms) |
| <input type="checkbox"/> | <input type="checkbox"/> | Renal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell: Trait <input type="checkbox"/> Disease <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | STI: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Substance Use (alcohol, tobacco, drugs) |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight gain or loss challenges |

Medications:

- Late Entry Into Prenatal Care**
(First prenatal visit after 1st trimester)
Check all that apply:
- Lack of health insurance
 - Unaware of the importance of prenatal care
 - Childcare issues
 - Unable to find a health provider
 - Unsure of keeping pregnancy to term
 - Financial problems
 - Unable to get an appointment in the first trimester
 - Other (specify): _____

OTHER HEALTH AND SOCIAL NEEDS (please answer all questions below)

You, Your Family and Partner

- Do you have children in your home or under your care? How many?
- Is your partner involved with your pregnancy?
- Is your husband or partner employed?
- Are you employed?
- Do you feel that you have enough help from your family or friends to care for your new baby?
- If you could change the timing of this baby would you want to?
- Did you consider adoption or abortion at any point during this pregnancy?

- Are you currently in foster care?
- Has CFSA been involved with any of your children?
- Are you currently working with a case manager, therapist, or counselor?
- Have you seen a probation officer in the last 12 months?
- Do you worry about getting food when you need it or getting good quality food?
- Do you currently receive WIC benefits?
- Do you currently receive food stamps/EBT?

Transportation, Housing and Environmental Exposures

- Have you moved in the last 3 months? How often?
- Are you homeless or worry that you could become homeless soon?
- Have any of your children had a positive blood test for lead?
- Do you have pets? What Kind? Cat Bird
Other: _____
- Do you have cockroaches and rodents in your home?
- Does anyone in your household smoke?
- Are there any leaks or mold in your home?
- Do you have any problems getting to doctor visits or appointments?

Domestic Violence (ACOG 3-Question Screen)

- Within the past year, or since you have been pregnant, have you be hit, slapped, kicked, or otherwise physically hurt by someone?
- Are you in a relationship with someone who threatens or physically hurts you?
- Has anyone forced you to have sexual activities that made you feel uncomfortable?

4 Ps Plus®

- Did either of your parents have a problem with drugs or alcohol?
- Does your partner have any problem with drugs or alcohol?
- Have you ever felt manipulated by your partner?
- Have you ever felt out of control or helpless?

Over the past 2 weeks:

- Have you felt down, depressed, or hopeless?
- Have you felt little interest or pleasure in doing things?

In the **month before** you knew you were pregnant:

- About how many cigarettes did you smoke per week?
 None Less than 1/2 pack About 1 pack More than 1 pack
- How many days per week did you drink beer/wine/liquor?
 None Less than 1 1-2 3-6 Everyday
- How many days per week did you use marijuana, cocaine or heroin?
 None Less than 1 1-2 3-6 Everyday

And **now**:

- About how many cigarettes do you smoke per week?
 None Less than 1/2 pack About 1 pack More than 1 pack
- How many days per week do you drink beer/wine/liquor?
 None Less than 1 1-2 3-6 Everyday
- How many days per week do you use marijuana, cocaine or heroin?
 None Less than 1 1-2 3-6 Everyday

Referrals: Referral completed (C) - check left box; Referral Needed (N) - check right box)

C N

- APRA/Substance Abuse Program
- Domestic Violence Services
- High Risk OB/Maternal Fetal Medicine
- Home Environment Assessment
- Home Visiting Agency
- Genetics
- MCO Care Coordination/Case Management:
Reason: _____
- Mental Health:
Reason: _____

C N

- Non-Obstetric Specialty Medical Care
- Nutritional Counseling/Nutritionist
- Oral Health/Dental Services
- Out of Plan Services Provider: _____
- Smoking Cessation Hotline/Services
- Social Work
- Support and Education Group: _____
- Teen Pregnancy Services
- WIC
- Other (specify): _____