Obstetrical Authorization & Initial Assessment

Health Plan:	---AmeriHealth----	---HSCSN---	---MedStar----	---TRUSTED---
Fax Number:	(888) 603-5526	(202) 721-7193	(202) 243-5496	(202) 821-1098
Tel. Number:	(877) 759-6883	(866) 937-4549	(855) 210-6203	(202) 821-1096

SUBMISSION DATE: ______________________

*** Should this patient receive MCO Case-management?** Yes / No

***Patient Referrals needed? (see below)** Yes / No

Member name (first, middle initial, last)

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Date of birth ☐☐/☐☐/☐☐☐☐

Member ID# or MA Recipient# ☐☐☐☐☐☐☐☐☐☐☐☐☐

Home phone # ☐☐☐ ☐☐☐-☐☐☐☐

Alternate phone # ☐☐☐ ☐☐☐-☐☐☐☐

Provider Name (Last name, first initial)

NPI or Provider Number

Phone # -

FAX# -

☐ **English not primary language; language spoken** ________________

Date of 1st Prenatal Visit	Gestational age	Gravida	Para	TAB	Live births
☐☐/☐☐/☐☐	☐☐ wks	☐☐	☐☐	☐☐	☐☐

EDC ☐☐/☐☐/☐☐

Hospital/Birthing Center for Delivery ☐ HUH ☐ Providence ☐ UMC ☐ WHC ☐ GWUH ☐ Other______________________

PAST Pregnancy Complications	Yes	No	**CURRENT Risk Factors (cont)**	Yes	No
Gestational Diabetes	☐	☐	Disability:	☐	☐
Incompetent cervix	☐	☐	Premature ROM	☐	☐
IUGR	☐	☐	Preterm dilation of cervix (>1.5cm) or Preterm Labor (<32 weeks)	☐	☐
Preeclampsia/Eclampsia	☐	☐	Previous delivery within 1 year	☐	☐
Premature ROM	☐	☐	Preeclampsia/Eclampsia	☐	☐
Preterm delivery <32 wks	☐	☐	Eating disorder ________________	☐	☐
Preterm delivery 32-36	☐	☐	Hepatitis_______________	☐	☐
Preterm labor <32 wks	☐	☐	Teen pregnancy	☐	☐
17-P Candidate?	☐	☐	Head of Household	☐	☐
C-Section	☐	☐	Thyroid disease ______________	☐	☐
Fetal loss (1st) (2nd) (3rd)	☐	☐	Anemia Hb <10	☐	☐
Infant or child death	☐	☐	Asthma	☐	☐
CURRENT Risk Factors	**Yes**	**No**	Obese BMI>40, BMI>30, Overweight BMI>25, Underweight BMI<19	☐ ☐ ☐	☐ ☐ ☐
Bleeding: 1st / 2nd /3rd (if 'yes' then circle trimester)	☐	☐	Chronic hypertension	☐	☐
Abnormal placenta	☐	☐	Clotting disorder______________	☐	☐
Gestational diabetes	☐	☐	Diabetes	☐	☐
Missed Prenatal Care	☐	☐	Seizure disorder	☐	☐
Oral problems: ___________	☐	☐	Cardiac_______________	☐	☐
Dental visit past 6 mos?	☐	☐	Renal disease________________	☐	☐
Weight gain or loss challenges	☐	☐	STI _____________________	☐	☐
HIV			Sickle cell disease		

Medications:

Referrals Needed:

Other Risks/Complications:

ALL questions must be completed for authorization of services

OTHER HEALTH NEEDS *(please answer all questions below)*

Member/ Patient Name: ____ ***Date of Birth*** ____/____/____

Housing, Nutrition and Transportation	**(Circle One)**		
How often have you moved in the last 3 months?	**Twice or more**	**Once**	**None**
Are you homeless or worry that you could become homeless soon?	**Yes**	**No**	
Do you have problems getting to doctor visits or other appointments?	**Yes**	**No**	
Do you worry about getting food when you need it or getting good quality food?	**Yes**	**No**	

Home and Partner	**(Circle One)**			
How many children are now in your home or under your care?	**3+**	**2**	**1**	**None**
How involved is the father of your baby with your pregnancy?	**Not at all**	**Somewhat**		**Very**
Is your husband or partner employed?	**No**	**Part-time**		**Yes**
Are you employed?	**No**	**Part-time**		**Yes**
Do you feel that you have enough help from your family or friends to care for your new baby?	**No**	**Maybe**		**Yes**
If you could change the timing of this baby, would you want to?	**Later**	**Earlier**		**No Change**

Experience with Child and Family Services (CFSA) or other government agencies	**(Circle One)**	
Are you currently in foster care?	**Yes**	**No**
Has CFSA been involved with any of your children?	**Yes**	**No**
Do you have a case manager, therapist, or counselor that you work with?	**Yes**	**No**
Have you seen a probation officer in the last 12 months?	**Yes**	**No**

Reason for Late Entry into Prenatal Care (Check all that apply)

If the date of the first visit for this pregnancy was later than the first trimester (after the first 12 weeks of pregnancy) was the reason for the delay:

- ☐ Insurance enrollment delay
- ☐ Unaware of the importance of prenatal care
- ☐ Childcare issues
- ☐ Unable to find a health provider
- ☐ Financial problems
- ☐ Other (specify) ________________________________

Environmental Exposures	**(Circle One)**	
Have any of your children tested positive for lead poisoning?	**Yes**	**No**
Do you have birds or cats in your home?	**Yes**	**No**
Does anyone in your household smoke?	**Yes**	**No**

Domestic Violence (ACOG 3-Question Screen)	**(Circle One)**	
1. Within the past year or since you have been pregnant have you been hit, slapped, kicked, or otherwise physically hurt by someone?	**Yes**	**No**
2. Are you in a relationship with someone who threatens or physically hurts you?	**Yes**	**No**
3. Has anyone forced you to have sexual activities that made you feel uncomfortable?	**Yes**	**No**

4 Ps Plus©

	Yes	No		Yes	No	**If an *Any is checked, continue with the 4 Ps Follow-Up Questions below.*
Did either of your parents have a problem with drugs or alcohol	☐	☐	**Have you ever drunk beer/wine/liquor**	☐	☐	
Does your partner have any problem with drugs or alcohol	☐	☐				
Have you ever felt manipulated by your partner	☐	☐		Any*	None	
Have you ever felt out of control or helpless	☐	☐	**In the month before you knew you were pregnant:**			
Over the past 2 weeks,			**how many cigarettes did you smoke**	☐	☐	
have you felt down, depressed, or hopeless	☐	☐	**how much beer/wine/liquor did you drink**	☐	☐	
have you felt little interest or pleasure in doing things	☐	☐	**how much marijuana did you use**	☐	☐	

4 Ps Plus Follow-up Questions (if an *Any above was checked)

In the month before you knew you were pregnant:	**Refer for Assessment**		**Prevention Education**		**No Referral Needed**
	every day	3-6 days/wk	1-2 days/wk	< 1 day/wk	(did not drink/use drugs)
About how many days a week ***did you*** usually					
drink beer / wine/ liquor?	☐	☐	☐	☐	☐
use any drug such as marijuana, cocaine, or heroin?	☐	☐	☐	☐	☐
And now, about how many days a week ***do you*** usually					
drink beer / wine/ liquor?	☐	☐	☐	☐	☐
use any drug such as marijuana, cocaine, or heroin?	☐	☐	☐	☐	☐