Obstetrical Needs Assessment Form

Member Information

Member ID Number:

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):	Telephone Number:
Address:	City, State, Zip Code:			
Email:	Date of initial prenatal visit/Diagnosis date:		Completion date of pregnancy form:	

Pregnancy Information and History

LMP	Gestational age at first visit	EDC	Gravida	Para	Pre-term	Living	Abortions
							Spontaneous:____Induced: ____

Risk Factors (past or current)

- ☐ No Risk Factors
- ☐ Diabetes/GDM/LGA baby
- ☐ DVT/PT
- ☐ Eclampsia/Pre-eclampsia
- ☐ Fetal congenital anomaly or disorder
- ☐ Fetal death
  - ☐ Second trimester ☐ Third trimester
- ☐ Hypertension/GHTN
- ☐ Incompetent cervix
- ☐ IUGR/SGA baby
- ☐ Late and/or inconsistent prenatal care
- ☐ Low birth weight < 2500 grams
- ☐ Multiple gestation
- ☐ Placenta abnormalities
  - ☐ Abruption ☐ Previa
- ☐ Premature ROM
- ☐ Pre-term (specify gestational age)
  - ☐ Delivery: _____
  - ☐ Labor: _____
- ☐ Renal Disease
- ☐ Sickle cell disease/trait
- ☐ Abnormal ultrasound: _____
- ☐ Uterine abnormality: _____
- ☐ Other: _____

Active Medical Conditions

- ☐ None
- ☐ Advanced maternal age
- ☐ Asthma
- ☐ Auto-immune disease(s)
  _____
- ☐ BMI (low or high): _____
- ☐ Hepatitis
- ☐ HIV
- ☐ Seizure disorder: _____

Thyroid disease - treated?

- ☐ Yes ☐ No
- ☐ Other (specify): _____

Social, Economic and Lifestyle Factors

- ☐ No Risk Factors
- ☐ Behavioral health condition
  _____
- ☐ Domestic violence
- ☐ Housing issues
- ☐ Identified social, economic and lifestyle
  _____
- ☐ Intellectual impairment
- ☐ Lack of support system
- ☐ Literacy issues
- ☐ Mental/physical/sexual abuse
  (current or history of): _____
- ☐ Postpartum depression
- ☐ Smoking/tobacco use; individualized intervention offered?
  - ☐ Yes ☐ No
- ☐ Substance abuse:
  - ☐ Alcohol: _____
  - ☐ Drug abuse: _____
- ☐ Teen pregnancy: _____
- ☐ Other (specify): _____

STI History

	Screen Date	Negative	Positive
☐ HIV:	_____	☐	☐
☐ Syphilis:	_____	☐	☐
☐ Gonorrhea:	_____	☐	☐
☐ Chlamydia:	_____	☐	☐

Current Medications

- ☐ No Medications

Please list: _____

Provider Information

Provider Name:	Tax ID Number:	Phone Number:	Fax Number:	Delivery Hospital:
Address:	City, State, Zip Code:			

Provider (MD/DO/APRN/PA): _____ Date: _____

Please fax form to the member's plan: Nebraska Total Care: 844-843-3890 WellCare Nebraska: 877-647-7475

UnitedHealthcare Community Plan of Nebraska: 877-353-6913