MIAMI CHILDREN'S
HEALTH PLAN
Florida's Family Health Plan

PREGNANCY NOTIFICATON FORM

Earliest completion of this form allows the Pregnancy Care Program to best utilize our resources and services to support you and your patient in achieving healthy pregnancy outcomes. **Please fax form to: 888-518-5333**

Date: ____/____/_____

OB Provider_________________________________ ID Number____________________________

Address____ Phone Number_________________________

ENROLLEE INFO

Medicaid Number_____________________ DOB ___/___/____

Last Name_______________________ First Name__________________________

Address____ Phone Number_______________________

City________________________ State______ Zip__________________

Preferred Language (if other than English) ____________ Interpreter Needed (Y/N) ____________

Date of 1st Prenatal Care Visit ___/___/____ EDD___/___/____ Height ___ft. ___in. Pre-Pregnancy Weight _____

Number of Full Term Deliveries_____

Number of Preterm Deliveries*_____

Number of Miscarriages/Abortions _____

Number of Stillbirths_____

Healthy Start Prenatal Screen Completed? (Y/N) _____

Healthy Start Referral? (Y/N) _____

WIC Referral Completed? (Y/N) _____

Previous C-Section(s) ☐ No ☐ Yes If yes, how many? _____

***To prior authorize Makena, please call 844-716-5413 or fax 866-265-5511**

PREGNANCY RISK ASSESSMENT

Active Medical/Behavioral Health Conditions

☐ Diabetes – Pregestational

☐ Chronic Hypertension

☐ Asthma

☐ Systemic Lupus Erythematosus

☐ Seizure Disorder ☐ Seizure within last 6 months

☐ Chronic Renal Disease

☐ Cardiac Disease

☐ Thyroid Disease

☐ Sickle Cell Disease

Current Pregnancy

☐ Young Maternal Age < 18 Years of Age

☐ Underweight – BMI < 18.5

☐ Obesity Class III – BMI > 40

☐ Short Interpregnancy Interval 6-12 Months

☐ Short Interpregnancy Interval < 6 Months

☐ Gestational Diabetes

☐ Hypertensive Disorder of Pregnancy*

*Please Specify_____________________________

☐ Multiple Gestation ☐ Twins ☐ Triplets ☐ Higher Order

Enrollee____ DOB ___/___/____

Active Medical/Behavioral Health Conditions

☐ HIV ☐ Negative ☐ Positive ☐ Refused Testing

☐ Serious Mental Illness or Severe Emotional Disturbance*

*Please Specify___________________________

☐ Depressive Disorder – Mild/Moderate

☐ Anxiety Disorder – Mild/Moderate

☐ Sexually Transmitted Infection*

*Please Specify___________________________

Pregnancy History

☐ Preterm Spontaneous Delivery < 37 Weeks*

*Currently on 17P/Makena (Y/N) ______

☐ Cervical Insufficiency in previous pregnancy

☐ Fetal death ≥ 20 weeks (stillbirth) in previous pregnancy

☐ Gestational Diabetes in previous pregnancy

☐ Hypertensive Disorder of Pregnancy in previous pregnancy

☐ Postpartum Depression in previous pregnancy

Current Pregnancy

☐ Shortened Cervix/Cervical Insufficiency

☐ Abnormal Placenta*

*Please Specify___________________________

☐ Congenital Anomalies*

*Please Specify___________________________

☐ Fetal Growth Restriction or Oligohydramnios

☐ Preterm Dilation of Cervix/Labor

☐ Substance Use < 3 months prior to pregnancy

☐ Substance Use/Substance Use Disorder*

*Please Specify___________________________

☐ Opioid Therapy*

*Please Specify___________________________

☐ Alcohol Use Amount____________________

☐ Prescription Opioid Use*

*Please Specify___________________________

☐ Tobacco or Electronic Nicotine Delivery System Use

☐ Homelessness/Unstable Housing

☐ Domestic/Interpersonal Violence

☐ Late Entry into Prenatal Care > 14 Weeks

☐ Inconsistent Prenatal Care

☐ Unwanted Pregnancy

☐ Lack of Transportation

☐ Financial Insecurity

☐ Food Insecurity

Other Significant Risk Factors or Barriers to Care ☐ No ☐ Yes Please list below