



Choices for a Healthy Life

PREGNANCY NOTIFICATION FORM

AMERIGROUP Community Care Peach State Health Plan Wellcare of Georgia, Inc.
Phone: 800-454-3730 Phone: 800-704-1483 Phone: 866-231-1821
Fax: 800-964-3627 Fax: 866-681-5125 Fax: 877-647-7475
ATTN: National Contact Center ATTN: Case Management ATTN: OB Department
http://www.amerigroupcorp.com http://www.pshpgeorgia.com http://georgia.wellcare.com

Please complete the areas highlighted in yellow in its entirety. Please type or write legibly.

Member Name: Physician Name: Expected date of delivery (EDD):
Member ID/Plan: Physician Telephone: Last Menstrual Period (LMP):
Member Address: Provider Number: First Prenatal Visit Date:
Provider Fax: Gravida: Para:
Member Telephone: Member Primary Language Spoken: Please put a check in the box that apply
Delivery Facility Name: Normal Pregnancy V22 High Risk Pregnancy V23
Mbr Age and DOB: Please Review Instructions Listed Below

SOCIAL RISK FACTORS: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

No Phone Unstable Living Arrangement Unemployed/DSS > 1 yr
Lives Alone No family support Barriers to receiving care
Transportation Problem WIC Referral given? Yes No Other:
Hx of Physical/Sexual Abuse Is this a current problem? Yes No Domestic Violence Screening:

MATERNAL MEDICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

DVT/Pulmonary Embolism Epilepsy on meds Current dental problems
Current Cigarette Use Hx STD's Primary Hypertension
Diabetes Mellitus Type I or II Hx of Pyelonephritis Asthma/COPD
Cardiac Condition Dental Care within last year Yes No Lupus
Thyroid Renal Condition Receiving Treatment HIV/AIDS Tested Y or N Test Declined?

PSYCHO-NEUROLOGICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

Clinical/Post Partum Depression Suicide Attempt Takes Medication for mental illness
Previous Counseling, Evaluation or Treatment, For how long? Desires Counseling Referral
Substance/Alcohol Abuse Hx Current Use? List Substance
Mentally/Physically Challenged

MATERNAL OBSTETRICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

Current PTL Hx of PTL Previous Uterine Surgery, Describe
Prev. Gest Diabetes Tocolytics used @ weeks gestation
Preg Induced Hypertension Abruptio Placenta Eating Disorder, List
Placenta Previa Pre-Eclampsia/PIH <12 months between births
Hyperemesis RH Negative Twins/Triplets Current Pa

PREVIOUS INFANT/FINDINGS: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

Stillbirth >28 wks Birthweight <2500 Gms Other
Preterm birth <30 wks Preterm Birth 30-36 wks Birthweight >4000 Gms

Please complete the questions listed below. Please type or write legibly.

Please list all current medications:
Please list any other medical/psychological problems not included above or other issues which may place this member at risk:
Patient at risk in pregnancy:
Provider Completing Form (please print): Title:
M.D. Signature: Date:

1. Do you want a home environment assessment to identify issues which may be impacting this pregnancy? Yes No (please circle selection)

2. Current Community Agencies Involved:

3. Does this member desire assistance with linking to community or other services (i.e. WIC)? Yes No (please circle selection)