Obstetrical risk assessment form

Patient information			
Last name:	First name:	Middle initial:	DOB (mm/dd/yyyy):
Address:			
City, state, ZIP code:		Telephone number:	
Member ID number:	Date of initial prenatal visit/diagnosis date:	Completion date of 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)	Active medical conditions	Social, economic and lifestyle factors
☐ No risk factors	☐ None	☐ No risk factors
☐ Diabetes/gestational diabetes/ LGA baby	☐ Advanced maternal age	☐ Behavioral health condition: _____
☐ DVT/PT	☐ Asthma	☐ Domestic violence
☐ Eclampsia/pre-eclampsia	☐ Auto-immune disease(s) _____	☐ Housing issues
☐ Fetal congenital anomaly or disorder	☐ BMI (low or high): _____	☐ Identified social, economic and lifestyle: _____
☐ Fetal death ☐ 2nd trimester ☐ 3rd trimester	☐ Hepatitis	☐ Intellectual impairment
☐ Hypertension/GHTN	☐ HIV	☐ Lack of support system
☐ Incompetent cervix	☐ Seizure disorder: _____	☐ Literacy issues
☐ IUGR/SGA baby	Thyroid disease — treated?	☐ Mental/physical/sexual abuse (current or history of): _____
☐ Late and/or inconsistent prenatal care	☐ Yes ☐ No	☐ Postpartum depression
☐ Low birth weight < 2500 grams	☐ Other (specify): _____	☐ Smoking/vaping/tobacco use; individualized intervention offered? ☐ Yes ☐ No
☐ Multiple gestation		☐ Substance use: ☐ Alcohol: _____ ☐ Drug: _____
☐ Placenta abnormalities ☐ Abruption ☐ Previa		☐ Teen pregnancy: _____
☐ Premature rupture of membranes		☐ Other (specify): _____
☐ Pre-term (specify gestational age) ☐ Delivery: _____ ☐ Labor: _____		
☐ Renal disease		
☐ Sickle cell disease/trait		
☐ Abnormal ultrasound: _____		
☐ Uterine abnormality: _____		
☐ Other: _____		

STI history				Current medications
	Screen date:	Negative	Positive	☐ No medications
☐ HIV:	_____	☐	☐	Please list: _____
☐ Syphilis:	_____	☐	☐	_____
☐ Gonorrhea:	_____	☐	☐	_____
☐ Chlamydia:	_____	☐	☐	_____

Provider information		
Last name:	First name:	Tax ID number:
Phone number:	Fax number:	Delivery hospital:
Address:	City, state, ZIP code:	

Is the provider requesting care coordination? ☐ Yes ☐ No

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

Please complete the enclosed form for each of your pregnant patients who are UnitedHealthcare Community Plan members within 15 calendar days of the member's first prenatal visit. Fax each form to **877-353-6913**.

For faster service, sign in to the UnitedHealthcare Provider Portal and use the Care Conductor tool for pregnancy notification and risk assessment.

UnitedHealthcare® Community Plan