Notification of Pregnancy Form

Fax completed form to Molina at (414) 214-2481

Member Information			
Last Name:	First Name:	DOB:	ID#:
Address:	City:	Zip:	Phone#:
Date of Initial Prenatal Visit:	Completion date of Pregnancy Form:		

Current Pregnancy ☐ In PNCC				
Gravida:	Para:	LMP:	EDC:	Blood Type:
Multiple Gestation previous pregnancy		Maternal age ≤ 16 years		Maternal age ≥ 35 years

Previous Pregnancy (Check all that apply)		
☐ HX of Placenta Pre	☐ Multiple Gestations previous pregnancy	
☐ HX of Post Partum Depression	☐ Preterm Labor/Delivery	☐ HX of SAB/TAB/Fetal Demise
☐ Previous C-Section	Week of Delivery:	Week of Demise:

Medical History (Check all that apply)		
☐ Cardiac Disease	☐ Clotting Disorders	☐ Hypertension or PIH (Current/Past)
☐ Respitory Conditions	☐ Behavioral Health Concerns	☐ Incompetent Cervix (Current/Past)
☐ HIV Status	☐ STD (Current/Past)	☐ Neurologic Disorders
☐ Sickle Cell Anemia		☐ Diabetes/Gestational Diabetes (Current/Past)

Psycho/Social Issues (Check all that apply)		
☐ Drug Abuse (Current/Past)	☐ Alcohol Abuse (Current/Past)	☐ Smoker (Current/Past)
☐ Domestic Abuse (Current/Past)	☐ Housing Issues	☐ Lack of Support System

Prenatal Care and Nutrition (Check all that apply)	
☐ Missed several medical appointments	☐ Currently enrolled in WIC
Description of above or other unlisted conditions:	
List of medications:	

Provider Information	
Provider Signature:	Provider Printed Name:
Provider Address:	Provider Phone#:
Delivery Hospital:	Provider Fax#: