# Prenatal notification form

Please complete all sections and fax to Molina Healthcare at 1-888-656-5098 to expedite case management.

## Member information

Member's name: Member ID #:

Address: City: State: Zip:

Member DOB: Phone: Primary language:

Date of positive pregnancy test: Date of first prenatal visit:

LMP: EDC: Gravida: Para: Living: AB:

## Current pregnancy risks and/or medical conditions *(Please check any that apply)*

- ☐ Diabetes
- ☐ Preeclampsia, and/or chronic hypertension
- ☐ Preterm labor
- ☐ Renal disease
- ☐ Heart disease
- ☐ Sickle cell disease
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Placenta previa
- ☐ Twins
- ☐ Seizure disorder
- ☐ Fetal anomaly
- ☐ Late and/or inconsistent prenatal care
- ☐ Homelessness
- ☐ Domestic violence
- ☐ Nutritional risk _____
- ☐ Psychiatric disorder _____
- ☐ Substance abuse _____
- ☐ Tobacco use _____
- ☐ Alcohol use _____
- ☐ STD _____
- ☐ Other risk and/or diagnosis _____

## Medical conditions from previous pregnancies *(Please check any conditions that apply)*

- ☐ Postpartum depression
- ☐ Hypertension
- ☐ Diabetes
- ☐ Preterm delivery
- ☐ Previous c-section
- ☐ Incompetent cervix
- ☐ Low birth weight <2500 grams
- ☐ Placenta previa
- ☐ Preeclampsia
- ☐ Gestational diabetes
- ☐ Spontaneous abortion or fetal demise
- ☐ PROM or PPROM

## Health screening *(Please add date completed)*

Health screening completion date:

## Provider information

Provider name: Provider ID:

Phone: Fax:

Address: City: State: Zip: