

# COOK CHILDREN'S HEALTH PLAN



## Pregnancy Notification



Please complete this form for notification by call or fax within one business day of the initial office prenatal visit or at the time of pregnancy diagnosis.

Please call or fax for authorization if your pregnant patient requires a hospital stay with or without delivery.

**Call: (682)885-2252 or (800)862-2247; Fax: (682)885-8402**

Member Name:	DOB:
Member ID #:	<input type="checkbox"/> CHIP <input type="checkbox"/> Medicaid/STAR
Other Health Insurance?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Insurance Name:
OB Name:	OB Phone #:
Office Contact:	OB Fax #:
Gravida/Para/AB/Living:	Expected Delivery Facility:
Expected Date of Delivery (EDC):	Last Menstrual Period (LMP):
Previous prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where:
Date of First OB Prenatal Office Visit:	Weeks Gestation at 1 <sup>st</sup> OB visit:
<b><u>RISK FACTORS:</u></b>	
<input type="checkbox"/> <b>PROBLEMS WITH THIS PREGNANCY:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Abnormal Lab(s)/sonogram(s) <input type="checkbox"/> Decreased Fetal Movement <input type="checkbox"/> Hyperemesis Gravidarum <input type="checkbox"/> Infection/GBS/HIV <input type="checkbox"/> Late Prenatal Care <input type="checkbox"/> No Prenatal Care <input type="checkbox"/> PIH (pregnancy > BP) <input type="checkbox"/> Pre-Eclampsia <input type="checkbox"/> Repeat Pregnancy < 12 months <input type="checkbox"/> STD/Herpes <input type="checkbox"/> Threatened AB <input type="checkbox"/> Young Maternal Age	
<input type="checkbox"/> Advanced Maternal Age <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Incompetent Cervix <input type="checkbox"/> IUGR <input type="checkbox"/> Multiple Gestation <input type="checkbox"/> Oligo/Polyhydramnios <input type="checkbox"/> Placenta Previa <input type="checkbox"/> Preterm Labor <input type="checkbox"/> SAB/Miscarriage <input type="checkbox"/> Substance Exposure [i.e. smoking] <input type="checkbox"/> Vaginal Bleeding <input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> <b>PROBLEMS WITH PREVIOUS PREGNANCY:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Anemia <input type="checkbox"/> DIC <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Preterm Delivery <input type="checkbox"/> Stillborn/Neonatal or Infant Death <input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> Birth defect(s) <input type="checkbox"/> Eclampsia <input type="checkbox"/> HELLP syndrome <input type="checkbox"/> SAB/Fetal Loss	
<input type="checkbox"/> C/Section <input type="checkbox"/> Ectopic <input type="checkbox"/> Low Birth Wt	
<input type="checkbox"/> <b>UNDERLYING MEDICAL PROBLEMS:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Asthma <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Obesity <input type="checkbox"/> UTI(s)	
<input type="checkbox"/> Blood/Sickle Cell/HIV <input type="checkbox"/> High BP (CHTN) <input type="checkbox"/> Pyelonephritis <input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> Diabetes (IDDM) <input type="checkbox"/> Immune Disorder <input type="checkbox"/> Trauma Injury	
<input type="checkbox"/> <b>OTHER RISK FACTORS/PROBLEMS:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Education <input type="checkbox"/> Social/Psych Issues <input type="checkbox"/> Financial <input type="checkbox"/> Transportation <input type="checkbox"/> Housing <input type="checkbox"/> OTHER: _____	
<b>Medications:</b> <input type="checkbox"/> NONE <input type="checkbox"/> Yes [If Yes, list]:	

**CCHP OB Care Authorization Number:** \_\_\_\_\_