



Obstetrical Needs Assessment Form

| Member Information | | | | Member ID Number: | |
|--------------------|-------------|--|-------------------|------------------------------------|--|
| Last Name: | First Name: | MI: | DOB (mm/dd/yyyy): | Telephone Number: | |
| Address: | | City, State, Zip Code: | | | |
| Email: | | Date of initial prenatal visit/Diagnosis date: | | Completion date of pregnancy 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 |
|---|--|---|
| <input type="checkbox"/> No Risk Factors <input type="checkbox"/> Diabetes/GDM/LGA baby <input type="checkbox"/> DVT/PT <input type="checkbox"/> Eclampsia/Pre-eclampsia <input type="checkbox"/> Fetal congenital anomaly or disorder <input type="checkbox"/> Fetal death <input type="checkbox"/> Second trimester <input type="checkbox"/> Third trimester <input type="checkbox"/> Hypertension/GHTN <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> IUGR/SGA baby <input type="checkbox"/> Late and/or inconsistent prenatal care <input type="checkbox"/> Low birth weight < 2500 grams <input type="checkbox"/> Multiple gestation <input type="checkbox"/> Placenta abnormalities <input type="checkbox"/> Abruption <input type="checkbox"/> Previa <input type="checkbox"/> Premature ROM <input type="checkbox"/> Pre-term (specify gestational age) <input type="checkbox"/> Delivery: _____ <input type="checkbox"/> Labor: _____ <input type="checkbox"/> Renal Disease <input type="checkbox"/> Sickle cell disease/trait <input type="checkbox"/> Abnormal ultrasound: _____ <input type="checkbox"/> Uterine abnormality: _____ <input type="checkbox"/> Other: _____ | <input type="checkbox"/> None <input type="checkbox"/> Advanced maternal age <input type="checkbox"/> Asthma <input type="checkbox"/> Auto-immune disease(s) <input type="checkbox"/> BMI (low or high): _____ <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Seizure disorder: _____ Thyroid disease - treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (specify): _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ | <input type="checkbox"/> No Risk Factors <input type="checkbox"/> Behavioral health condition <input type="checkbox"/> Domestic violence <input type="checkbox"/> Housing issues <input type="checkbox"/> Identified social, economic and lifestyle <input type="checkbox"/> Intellectual impairment <input type="checkbox"/> Lack of support system <input type="checkbox"/> Literacy issues <input type="checkbox"/> Mental/physical/sexual abuse (current or history of): _____ <input type="checkbox"/> Postpartum depression <input type="checkbox"/> Smoking/tobacco use; individualized intervention offered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Substance abuse: <input type="checkbox"/> Alcohol: _____ <input type="checkbox"/> Drug abuse: _____ <input type="checkbox"/> Teen pregnancy: _____ <input type="checkbox"/> Other (specify): _____ _____ _____ |

| STI History | Current Medications | | | | | | | | | | | | | | | | | | | | |
|--|---------------------|--------------------------|--------------------------|----------|-------------------------------|-------|--------------------------|--------------------------|------------------------------------|-------|--------------------------|--------------------------|-------------------------------------|-------|--------------------------|--------------------------|-------------------------------------|-------|--------------------------|--------------------------|--|
| <table border="1"> <thead> <tr> <th></th> <th>Screen Date</th> <th>Negative</th> <th>Positive</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> HIV:</td> <td>_____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Syphilis:</td> <td>_____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Gonorrhea:</td> <td>_____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chlamydia:</td> <td>_____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> | | Screen Date | Negative | Positive | <input type="checkbox"/> HIV: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Syphilis: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Gonorrhea: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chlamydia: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> No Medications Please list: _____ _____ _____ _____ |
| | Screen Date | Negative | Positive | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> HIV: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Syphilis: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Gonorrhea: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Chlamydia: | _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |

| Provider Information | | | | |
|----------------------|----------------|------------------------|-------------|--------------------|
| Provider Name: | Tax ID Number: | Phone Number: | Fax Number: | Delivery Hospital: |
| Address: | | City, State, Zip Code: | | |

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

Please fax form to the member's plan: *Molina Healthcare of Nebraska* 833-352-2359
 Nebraska Total Care 844-843-3890
 UnitedHealthcare Community Plan of Nebraska 402-445-5730