OBSTETRIC NOTIFICATION RISK ASSESSMENT FORM

Pt Name	**HUSKY ID #**		**DOB**
Address	City	State	ZIP
Phone	**Primary language**	**Race**	

Gravida	**Para**	**EAB**	**SAB**	**Number of Living Children**
~~**Date of 1st contact by pt:**~~		**1st prenatal visit:**		~~**Date of 1st appt accepted by pt (optional):**~~

Provider	**Provider Plan ID:**
Office Phone	**Office FAX**
Prenatal Care Provider/Practice	**Hospital for Delivery**

Does the pt have risk factors? Yes *No* ***<u>If yes, please complete Section I.</u>***	**EDD** **LMP**	
Please identify all risks that apply in this pregnancy or previous pregnancy	**Circle if Yes or No**	
Section I **RISK FACTORS**	**Risk**	~~**History of**~~
~~Depression~~	Yes No	~~Yes No~~
~~Anxiety~~	Yes No	~~Yes No~~
~~Affective Disorder~~	Yes No	~~Yes No~~
BMI [ ] http://www.nhlbisupport.com/bmi/		
Obesity	Yes No	~~Yes No~~
Underweight	Yes No	~~Yes No~~
Has the pt ever smoked?	Yes No	~~Yes No~~
Current smoker?	Yes No	~~Yes No~~
• If yes, was the pt referred to a smoking cessation program? (~~IQuit~~, CT Quit Line)	Yes No	
~~Substance Abuse-ETOH~~	Yes No	~~Yes No~~
~~Substance Abuse-Drugs~~	Yes No	~~Yes No~~
~~Trauma~~	Yes No	~~Yes No~~
Violence	Yes No	~~Yes No~~
Homeless	Yes No	~~Yes No~~
Transportation Issues	Yes No	~~Yes No~~
~~Previous C-Section~~	Yes No	~~Yes No~~
Hyperemesis	Yes No	~~Yes No~~
Cervix Incompetent / Short (<2.5cm) / Cerclage	Yes No	~~Yes No~~
Multiple Gestation 2, 3, 4 , 5	Yes No	~~Yes No~~
Advanced Maternal Age	Yes No	~~Yes No~~
Preterm Labor	Yes No	~~Yes No~~
Preterm Birth	Yes No	~~Yes No~~
Gestational Diabetes	Yes No	~~Yes No~~

Pt Name	**HUSKY ID #**	**DOB**

Section I (Continued) **RISK FACTORS**	**Risk**	~~**History of**~~
Diabetes- Type 1, Type2, Pre-diabetes, PCOS	Yes No	~~Yes No~~
Pre-eclampsia/Eclampsia, Pregnancy Induced Hypertension, Chronic Hypertension	Yes No	~~Yes No~~
Previous poor pregnancy outcome (i.e.LBW, Fetal Death, Placenta Previa, NICU stay &/or other serious risk)	Yes No	~~Yes No~~
Medications (including OTCs):		
Other Identified Risks:		

HIV Test/Info Offered:	Yes No	Pt declined	Will offer at a future Appt
WIC Referral Made:	Yes No	Pt declined	Will offer at a future Appt
Signature of Clinician's Representative			Date

Section 2
Postpartum Notification

EDD	
Total number of prenatal visits	
~~Actual date of delivery~~	
~~Gestational Age~~	
~~Birth Weight~~	
~~Type of Delivery~~	~~Vaginal~~ ~~C-Section~~
Postpartum Appointment Date and date of delivery	
PP Depression Screening	Yes / No ~~If yes, was the screening:~~ ~~Negative~~ ~~Positive~~
~~Did the pt have any prenatal morbidity?~~	~~Yes/No~~ ~~If yes, was the pt counseled on the appropriative PP follow up care.~~

Clinician's Signature	Date