TUFTS Health Plan

Massachusetts Health Quality Partners Obstetrical Risk Assessment Form

Name____ Health Plan & Subscriber ID#__________________
Last First Middle
Address____
Street Apt.# City State Zip
Phone #: Home__________________________________ Work__________________________________ Date of Birth ______/______/______

Obstetrical Clinician's Name____ OB Provider ID #__________________

Obstetrical Provider's Phone #___________________________________ Fax #___________________________ EDC ______/______/______

Planned Hospital for Delivery ____ 1st Prenatal Visit Date: ______/______/______

Race: White ☐ Black☐ Asian/Pacific Islander☐ American Indian☐ Other☐
Ethnicity: Hispanic☐ Non Hispanic☐ Language spoken at home______________________________
Needs translation help ☐ Yes ☐ No Support System ☐ Yes ☐ No

BEHAVIORAL RISKS

Smoking Status

Smokes regularly now, about the same as prior to pregnancy
☐ Yes ☐ No

Smokes regularly now but less than prior to the pregnancy
☐ Yes ☐ No

Smokes every once and a while ☐ Yes ☐ No

Quit smoking since becoming pregnant ☐ Yes ☐ No

Wasn't smoking when became pregnant and doesn't smoke now
☐ Yes ☐ No

Occupational Demands

Sedentary ☐ Active ☐ Hours spent standing __________

Psychosocial Assessment completed ☐ Yes ☐ No

Psychosocial risk factors identified: (please check)
1. frequent moves ☐ 2. care access ☐ 3. hungry ☐
4. education ☐ 5. safe ☐ 6. violence ☐ 7. stress ☐
8. pregnancy planning ☐

Substance Abuse

Is the patient currently using alcohol? ☐ Yes ☐ No

Is the patient currently using street drugs? ☐ Yes ☐ No

In the month prior to pregnancy:

How many drinks did the patient consume in one week?

____

On how many occasions did the patient have more than 3 drinks?

____

OBSTETRICAL HIGH RISK/PRE-TERM LABOR ASSESSMENT

Gravida_________ Full Term __________ Pre-term__________ Abs__________ Living ___________ Height___________ Weight___________
Previous C/S? ☐ Yes ☐ No VBAC discussed ☐ VBAC planned ☐ VBAC refused ☐ VBAC medically inappropriate ☐

Risk Factors: Past OB/GYN History Including Past Pregnancies Initial Screen Date ______/______/______
Pre-term labor with previous pregnancy (less than 37 weeks)........ ☐ Yes ☐ No
Pre-term delivery with previous pregnancy (less than 37 weeks)........ ☐ Yes ☐ No
Diagnosis associated with pre-term delivery (narrative):____
Incompetent cervix ☐ Yes ☐ No Cerclage with previous pregnancy ☐ Yes ☐ No
DES Exposure........ ☐ Yes ☐ No
Two or more 2nd trimester........ ☐ Yes ☐ No
Delivery within the past 12 months........ ☐ Yes ☐ No
Prior cone biopsy ☐ Yes ☐ No Known uterine anomalies ☐ Yes ☐ No Uterine fibroids ☐ Yes ☐ No Myomectomy ☐ Yes ☐ No

Risk Factors: Current Pregnancy 26-28 weeks screening date ______/______/______
ART this pregnancy ☐ Yes ☐ No Gonadotropin ☐ Yes ☐ No Clomophine ☐ Yes ☐ No Multiple gestations ☐ Yes ☐ No
Fetal reduction ☐ Yes ☐ No Presence of Bacterial Vaginosis this pregnancy ☐ Yes ☐ No Treatment for BV ☐ Yes ☐ No
Bleeding after 12 weeks this pregnancy........ ☐ Yes ☐ No
Pre-term labor this pregnancy ☐ Yes ☐ No Cervical changes ☐ Yes ☐ No Cerclage ☐ Yes ☐ No
Placenta previa beyond 26 weeks, this pregnancy ☐ Yes ☐ No
Polyhydramnios this pregnancy........ ☐ Yes ☐ No
Pregnancy included hypertension, this pregnancy........ ☐ Yes ☐ No
Gestational Diabetes this pregnancy........ ☐ Yes ☐ No
Other risk factors current or past pregnancy (narrative)........ ☐ Yes ☐ No

I hereby authorize the Provider indicated herein to release the information on this form to Tufts Health Plan.

________________________________ ________________________________ Provider Services

Signature of Member Date Signature of Provider Date