Georgia Families
Choices for a Healthy Life

PREGNANCY NOTIFICATION FORM

AMERIGROUP Community Care	Peach State Health Plan	Wellcare of Georgia, Inc.
Phone: 800-454-3730	Phone: 800-704-1483	Phone: 866-231-1821
Fax: 800-964-3627	Fax: 866-681-5125	Fax: 877-647-7475
ATTN: National Contact Center	ATTN: Case Management	ATTN: OB Department
http://www.amerigroupcorp.com	http://www.pshpgeorgia.com	http://georgia.wellcare.com

Please complete the areas highlighted in yellow in its entirety. Please type or write legibly.

Member Name:		Physician Name:	Expected date of delivery (EDD):
Member ID/Plan:		Physician Telephone:	Last Menstrual Period (LMP):
Member Address:		Provider Number:	First Prenatal Visit Date:
		Provider Fax:	Gravida: Para:
Member Telephone:		Member Primary Language Spoken:	**Please put a check in the box that apply**
Delivery Facility Name:		**Please Review Instructions Listed Below**	☐ Normal Pregnacy V22 ☐ Hig Risk Pregnancy V23
Mbr Age and DOB:	_____/_____		

SOCIAL RISK FACTORS: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

☐ No Phone	☐ Unstable Living Arrangement	☐ Unemployed/DSS > 1 yr
☐ Lives Alone	☐ No family support	☐ Barriers to receiving care
☐ Transportation Problem	☐ WIC Referral given? Yes No	☐ Other:_____
☐ Hx of Physical/Sexual Abuse	☐ Is this a current problem? Yes No	☐ Domestic Violence Screening:_____

MATERNAL MEDICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

☐ DVT/Pulmonary Embolism	☐ Epilepsy on meds	☐ Current dental problems
☐ Current Cigarette Use	☐ Hx STD's	☐ Primary Hypertension
☐ Diabetes Mellitus Type I or II	☐ Hx of Pyeloneprhitis	☐ Asthma/COPD
☐ Cardiac Condition	☐ Dental Care within last year Yes No	☐ Lupus
☐ Thyroid	☐ Renal Condition Receiving Treatment	HIV/AIDS Tested Y or N Test Declined?_____

PSYCHO-NEUROLOGICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

☐ Clinical/Post Partum Depression	☐ Suicide Attempt	☐ Takes Medication for mental illness
☐ Previous Counseling, Evaluation or Treatment, For how long?_____		☐ Desires Counseling Referral
☐ Substance/Alchohol Abuse Hx	☐ Current Use? List Substance_____	
☐ Mentally/Physically Challenged		

MATERNAL OBSTETRICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

☐ Current PTL ☐ Hx of PTL	☐ Previous Uterine Surgery, Describe _____	
☐ Prev. Gest Diabetes	☐ Tocoloytics used @ _____ weeks gestation	
☐ Preg Induced Hypertension	☐ Abrubtio Placenta	☐ Eating Disorder, List _____
☐ Placenta Previa	☐ Pre-Eclampsia/PIH	☐ <12 months between births
☐ Hyperemesis	☐ RH Negative	☐ Twins/Triplets ☐ Current Pa☐

PREVIOUS INFANT/FINDINGS: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

☐ Stillbirth >28 wks	☐ Birthweight<2500 Gms	☐ Other
☐ Preterm birth<30 wks	☐ Preterm Birth 30-36 wks	☐ Birthweight >4000 Gms

Please complete the questions listed below. Please type or write legibly.

Please list all current medications:_____

Please list any other medical/psychological problems not included above or other issues which may place this member at risk:_____

Patient at risk in pregnancy:_____

Provider Completing Form(please print):_____ Title:_____

M.D. Signature: _____ Date:_____

1. Do you want a home environment assessment to identify issues which may be impacting this pregnancy? Yes No (please circle selection)

2. Current Community Agencies Involved:_____

3. Does this member desire assistance with linking to community or other services (i.e. WIC)? Yes No (please circle selection)