

Notification of Pregnancy Form

Last Name*

First Name* DOB* (mmddyyyy)

History (place a thick X for all that apply):

High Blood Pressure (prior to pregnancy)?

Well controlled?

Previous neonatal death or stillborn?.....

Associated with maternal health condition?.....

HIV positive? HIV negative? Testing refused?

AIDS?

Seizure disorder?

Seizure within the last 6 months?

Previous alcohol or drug abuse?

Current Pregnancy (place a thick X for all that apply):

BMI <20 or poor weight gain this pregnancy?

UTI/Pyelo/Bacteriuria this pregnancy?

Current severe hyperemesis?.....

Current mental health concerns?.....

List

Current STD? List

Current tobacco use? Amount

Current alcohol use? Amount

Current street drug use?.....

Any social needs? Yes No Please list below.

Other Significant Risk Factors Yes No Please list below.

Date (mmddyyyy)

OB Provider Name*

TIN/ID Number* Phone Number - -

Mailing Address

City State Zip Code

If you would like your patient to receive a free 3 month supply of prenatal vitamins, please complete the Prenatal Vitamin Form. For any questions regarding this form or the Start Smart program, please call 1-877-644-4623.

