Obstetrical risk assessment form

Patient information			
Last name:	First name:	Middle	DOB (mm/dd/
Address:			
City, state, ZIP code:		Telephone number:	
Member ID number:	Date of initial prenatal visit/diagnosis date:	Completion date of 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
No risk factors	None	No risk factors
Diabetes/gestational diabetes/ LGA baby	Advanced maternal age	Behavioral health condition:
DVT/PT	Asthma	Domestic violence
Eclampsia/pre-eclampsia	Auto-immune disease(s)	Housing issues
Fetal congenital anomaly or disorder		Identified social, economic and lifestyle:
Fetal death 2nd trimester 3rd trimester	BMI (low or high):	Intellectual impairment
Hypertension/GHTN	Hepatitis	Lack of support system
Incompetent cervix	HIV	Literacy issues
IUGR/SGA baby	Seizure disorder:	Mental/physical/sexual abuse (current or history of):
Late and/or inconsistent prenatal care	Thyroid disease — treated? Yes No	Postpartum depression
Low birth weight < 2,500 grams	Other (specify):	Smoking/vaping/tobacco use; individualized intervention offered?
Placenta abnormalities Abruption Previa		Substance use: Alcohol: Drug:
Premature rupture of membranes		Teen pregnancy:
Pre-term (specify gestational age) Delivery: Labor:		Other (specify):
Renal disease		
Sickle cell disease/trait		
Abnormal ultrasound:		
Uterine abnormality		
Other:		

United Healthcare Community Plan

STI history				Current medications
	Screen date	Negative	Positive	No medications
HIV				(Please list:)
Syphilis				
Gonorrhea				
Chlamydia				

Provider information

Last name:	First name:	Tax ID number:
Phone number:	Fax number:	Delivery hospital:
Address:	City, state, ZIP code:	

Is the provider requesting care coordination? Yes No

Provider (M.D./DO/APRN/PA): Date:

Please complete the enclosed form for each of your pregnant patients who are UnitedHealthcare Community Plan members within 15 calendar days of the member's first prenatal visit. Fax each form to **877-353-6913**.

For faster service, sign in to the UnitedHealthcare Provider Portal and use the Care Conductor tool for pregnancy notification and risk assessment.

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