

OBSTETRICAL PRE-REGISTRATION FORM

Member's Name: _____ Subscriber ID #: _____
Last First Middle

Member's Address: _____
Address City State Zip

Phone: Home () _____ Work () _____ DOB _____ Under 17 Yrs of Age Y or N/High School Grad Y or N

PCP's Name & ID#: _____

Obstetrical Provider's Name & ID#: _____

Health Plan: _____

Planned Hospital for Delivery: _____ EDC: _____ 1st Prenatal Visit Date: _____

Planned Type of Delivery: NVD () VBAC () C-Section () Repeat C-Section () Indication for C-Section: _____

Does member currently smoke? Yes () No () If so, how many cigarettes smoked per day? _____

If available, does the member wish to receive educational information? Yes () No ()

OBSTETRICAL HIGH RISK/PRE-TERM LABOR ASSESSMENT FORM

Age _____ Gravida _____ Para _____ Full Term _____ Pre-term _____ Abs _____ Living _____

Risk Factors	Initial Screen (Date): _____	Follow-up Screen (Date): _____
Previously treated Pre-term labor and/or delivery (prior pregnancy)		
Incompetent cervix/DES exposure/Cerclage		
Two (2) or more second trimester spontaneous abortions		
Uterine Anomalies/Uterine Fibroids		
Prior cone Bx/Anomalies/Uterine Fibroids		
Multiple gestation		
Substance/Alcohol abuse		
a) Number of drinks per week during pregnancy		
Bacturia		
Bleeding at 12 weeks or more		
Pre-term labor with present pregnancy		
Effacement > 50%, Cervical Dilation > 1 cm < 34 weeks, Uterine irritability < 34 weeks.		
Placenta previa > 26 weeks		
Polyhydramnios		
Gestational Diabetes		
PIH (Pregnancy Induced Hypertension)		

I hereby authorize the Provider indicated herein to release the above information to the above named Health Plan.

Signature of Member _____ (Date) _____ Signature of Provider _____ (Date) _____

MAIL OR FAX TO: **Health New England • Attn: HSM • One Monarch Place • Springfield, MA 01144 • (413) 233-2700**

Check here if you wish a Case Manager to contact you about this patient