Steward Health Care Network

HEALTH CHOICE GENERATIONS

TOTAL OB PRE-AUTHORIZATION

Maternal Health Risk Assessment

For questions about this form call: (800) 828-7514

Fax completed form to: (480) 760-4762

Date of Request: _____ **Please ATTACH A COPY OF THE PRENATAL RECORD**

MEMBER INFORMATION

Name: _____ AHCCCS ID: _____

Phone: _____ DOB: _____ Age: _____

PROVIDER INFORMATION

Name: _____ NPI: _____

Phone: _____ Fax: _____

Contact Person: _____ Extension: _____

US Facility_____ US Facility NPI# _____

CLINICAL INFORMATION ☐ WIC Referral Complete

LMP: _____ (☐ not known) EDD: _____ (From ☐ LMP ☐ U/S) ☐ HIV Screening Complete

Date of entry into prenatal care: _____ Date of first Visit in Provider's office: _____

***Note: If all information below is found on the attached prenatal record, it is not necessary to continue.**

Pre-Pregnancy Weight: _____ (☐ not known) Current Weight: _____ Height: _____

History	**Number (indicate if none)**	**Number (indicate if none)**
Total # Pregnancies:	_____	# Living Children _____
# Deliveries after 37 0/7 weeks:	_____	# Miscarriages/Terminations: _____
# Deliveries 32 0/7 – 36 6/7 weeks:	_____	# Cesarean deliveries: _____
# Deliveries before 32 weeks:	_____	# VBAC deliveries: _____

Condition (Check all that apply)	**Current**	**Prior**
TWINS	☐	☐
OTHER MULTIPLE_____	☐	☐
GESTATIONAL DIABETES	☐	☐
TYPE 1 or 2 DIABETES	☐	☐
PIH / PRE-ECLAMPSIA	☐	☐
ECLAMPSIA	☐	☐
CHRONIC HYPERTENSION	☐	☐
FETAL ANOMALIES	☐	☐
GENETIC DISORDER	☐	☐
BEHAVIORAL HEALTH	☐	☐
DOMESTIC VIOLENCE	☐	☐
OTHER OBSTETRICAL COND	☐	☐
OTHER MEDICAL CONDITIONS	☐	☐

Condition (Check all that apply)	**Current**	**Prior**
PRETERM BIRTH	☐	☐
INCOMPETENT CERVIX	☐	☐
PLACENTA PREVIA	☐	☐
PLACENTAL ABRUPTION	☐	☐
POST PARTUM HEMORRHAGE	☐	☐
SEIZURE DISORDER	☐	☐
HEART DISEASE	☐	☐
RENAL DISEASE	☐	☐
HEPATIC DISEASE	☐	☐
INFECTIOUS DISEASE	☐	☐
SUBSTANCE ABUSE	☐	☐
TOBACCO USE	☐	☐
HIV	☐	☐

If checked, please explain _____

_____

_____

_____