



OBSTETRICS RISK ASSESSMENT

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Complete and fax this form to: (877)353-6913

| Date Assessment Completed: | | | | |
|--|---|---------------------------------------|--|----------------------------------|
| Patient Demographics | | | | |
| Patient Name | | | Insurance ID/ Medicaid #: | |
| Last: | First: | M.I.: | DOB: | |
| Street Address: | | City: | State: | Zip Code: |
| Home Phone: | | | Cell Phone: | |
| Race/Ethnicity: | <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Native American | Primary Language |
| | <input type="checkbox"/> Asian | <input type="checkbox"/> Multi-Racial | <input type="checkbox"/> Hispanic | |
| | <input type="checkbox"/> Other | | | <input type="checkbox"/> Spanish |
| | | | <input type="checkbox"/> Other _____ | |
| Provider Demographics | | | | |
| Practice Name: | Provider Name/Type: | NPI/TIN: | Office Location: | |
| | Provider Signature: | | | |
| Patient Information | | | | |
| Date of First Prenatal Visit: | | Estimated Due Date: | Gravida: | Para: |
| Medical Conditions (check all that apply) | | | | |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> STD <input type="checkbox"/> HIV <input type="checkbox"/> Other _____ | | | | |
| Obstetrical Considerations (check all that apply) | | | | |
| <input type="checkbox"/> Hx preterm delivery <input type="checkbox"/> Candidate for progesterone therapy <input type="checkbox"/> Hx C-section, indication: _____ <input type="checkbox"/> Bleeding after 12 weeks <input type="checkbox"/> Multiple gestation <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> Genetic risk <input type="checkbox"/> Other _____ | | | | |
| Behavioral Status (check all that apply) | | | | |
| <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other psychiatric diagnosis <input type="checkbox"/> SUD <input type="checkbox"/> Smoking <input type="checkbox"/> Other _____ | | | | |
| Social Conditions (check all that apply) | | | | |
| <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Other support system needs <input type="checkbox"/> Homelessness <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Other resource needs <input type="checkbox"/> Known to state social service system <input type="checkbox"/> Other _____ | | | | |
| Plan of Care | | | | Additional Notes |
| POC Item | Referred | Enrolled | Completed | Refused |
| <input type="checkbox"/> Preterm labor prevention | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Domestic violence assistance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Substance use disorder treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Mental health support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Childbirth education | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other community resources | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> SSI | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Smoking cessation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> MFM/other specialist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nutrition consultation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Breastfeeding education | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> WIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | How Can We Help You? |
| The Healthy First Steps program is available to assist with complications or barriers you identify during the course of your patient's pregnancy and postpartum period. You can reach a Healthy First Steps representative by calling (800) 599-5985 . | | | | |