



# Prenatal Registration Form

Tufts Health Plan Commercial Fax:

617-972-9417

Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Pregnancy care information

Provider name \_\_\_\_\_ NPI# \_\_\_\_\_

Provider address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Provider phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Provider fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## Member information *Please verify the member's eligibility before rendering services.*

Member name \_\_\_\_\_ Member ID # \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Member address \_\_\_\_\_ Member phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Race ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian ☐ Other \_\_\_\_\_

Ethnicity \_\_\_\_\_ Language spoken at home \_\_\_\_\_ Need translation help ☐ Yes ☐ No

LMP \_\_\_\_/\_\_\_\_/\_\_\_\_ G P EDD \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of first prenatal visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent prenatal visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of last delivery \_\_\_\_\_ Date of last delivery \_\_\_\_/\_\_\_\_/\_\_\_\_

## Expected delivery facility (required)

## Risk assessment *Check all applicable risks. You may attach your own risk assessment form if necessary.*

### BEHAVIORAL RISKS

- ☐ Smokes more than 10 cigarettes per day
- ☐ Less than two years since last pregnancy
- ☐ Directed member to WIC office
- ☐ Offered member HIV counseling
- ☐ Substance abuse in pregnancy

### PSYCHOLOGICAL RISKS

- ☐ Adolescent
- ☐ Inadequate finances
- ☐ Inadequate housing
- ☐ Inadequate social supports
- ☐ Involvement with other agencies, e.g., DYS, DCF
- ☐ Less than high school education
- ☐ Poor nutrition
- ☐ Psychiatric history
- ☐ Significant learning disabilities
- ☐ Violence/abuse

### MEDICAL RISKS

- ☐ Cardiac disease
- ☐ Diabetes
- ☐ Endocrine disorders
- ☐ GI disorders
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Malignancy
- ☐ Moderate or severe asthma
- ☐ Renal disease/history of urinary tract infections (UTIs)
- ☐ Seizure disorders
- ☐ Sickle cell disease

### OBSTETRIC RISKS

- ☐ Abnormal Pap smear
- ☐ Anemia
- ☐ BMI > 30
- ☐ Gestational diabetes
- ☐ History of cervical uterine infections
- ☐ History of infant with birth injury, neurological deficit, or congenital anomaly
- ☐ History of infertility
- ☐ History of low-birth-weight infant
- ☐ Inadequate prenatal care
- ☐ Incompetent cervix
- ☐ Intrauterine growth retardation (IUGR)
- ☐ Placenta previa/placenta abruptia
- ☐ Polyhydramnios/oligohydramnios
- ☐ Poor weight gain
- ☐ Postpartum depression – family history
- ☐ Postpartum depression – personal history
- ☐ Pregnancy-induced hypertension (PIH)
- ☐ Pre-pregnancy weight of less than 100 pounds
- ☐ Previous preterm labor (PTL)
- ☐ Previous preterm delivery (PTD)
- ☐ Previous stillborn/neonatal death
- ☐ Multiple gestation
- ☐ Rh sensitization
- ☐ Sexually transmitted diseases (STDs)
- ☐ Two or more spontaneous abortions (SABs) or therapeutic abortions (TABs)
- ☐ Uterine/cervical anomaly

OB/GYN provider signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Form available at: [tuftshealthplan.com/provider](http://tuftshealthplan.com/provider)

Phone: 888-766-9818 ext. 53532