

# Notification of Pregnancy Form

The earliest possible completion of this form allows the Start Smart for your Baby® program to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to: 866-681-5125.**



## Member Info

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Member ID# \_\_\_\_\_  
 DOB \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Cell Phone # \_\_\_\_\_ Email Address \_\_\_\_\_  
 Other insurance \_\_\_\_\_ ID# \_\_\_\_\_ Policy Holder \_\_\_\_\_  
 Date of 1st visit \_\_\_\_\_ EDC \_\_\_\_\_ Delivery Hospital \_\_\_\_\_  
 Gravida \_\_\_\_\_ Para \_\_\_\_\_ Planning to breastfeed?  Yes  No  
 SAB \_\_\_\_\_ EAB \_\_\_\_\_ HIV tested?  Yes  No Refused?  Yes  No  
 Mother enrolled in WIC?  Yes  No Pediatrician chosen?  Yes  No Name \_\_\_\_\_

## Pregnancy risk assessment (mark all that apply)



- Previous Preterm Delivery (<37 weeks)
  - Previous second trimester loss (14-24 weeks) or Stillborn/week \_\_\_\_\_
  - Previous Cesarean Section
  - Personal history of clotting disorder or family history of thrombotic event
  - Mental illness
  - Domestic Violence (history or current)
  - Smoker
  - Alcohol abuse
  - Drug abuse
  - 17 years or younger
  - 35 years or older
  - Other significant risk factor \_\_\_\_\_
  - No known risk factors
- Preexisting Medical Condition**
- Diabetes
  - Hypertension
  - Asthma
  - Sickle cell
- Current pregnancy**
- Gestational diabetes
  - Sexually transmitted disease
  - Preterm labor or incompetent cervix
  - IUGR
  - Oligohydramnios
  - Preeclampsia
  - Placenta previa
  - Multiple gestation

Please complete if you would like your patient to receive a free three (3) month's supply of prenatal vitamins. They will be shipped to (please choose)  Provider Office  Member  
 [Please make sure accurate mailing address is on this form.]

## Provider Info

Name \_\_\_\_\_  
 Provider T.I.N. or N.P.I.# \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Fax # \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**For any questions regarding this form or the Start Smart program please call 1-866-246-4358.**

	
Name _____ Date _____ Date of Birth _____	
<b>Prenatal Plus                  Disp: #100                  No refills</b>	
_____ Physician signature / Dispense as written	
DEA# _____	
Prescription is void if more than one (1) prescription is written per blank.	

Completed by _____	Date _____	For Health Plan Use Only <input type="checkbox"/>
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