AmeriHealth Caritas Next

A product of AmeriHealth Caritas North Carolina, Inc.

Pregnancy Medical Home Risk Screening Form

Practice name:	Practice phone number:		Today's date: / /
First name:	MI:	Last name:	Date of birth: / /
EDC: / /	By what criteria: ☐ LMP ☐ 1st trimester U/S ☐ 2nd trimester U/S		
Height:	Pre-pregnancy weight:	Gravidity:	Parity: ___T ___P ___A ___L
Insurance type: ☐ Private ☐ None			

Current pregnancy

☐ Multifetal gestation

☐ Fetal complications:

- ☐ Fetal anomaly
- ☐ Fetal chromosomal abnormality
- ☐ Intrauterine growth restriction (IUGR)
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Other:

☐ Chronic condition that may complicate pregnancy:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Asthma
- ☐ Mental illness
- ☐ HIV
- ☐ Seizure disorder
- ☐ Renal disease
- ☐ Systemic lupus erythematosus
- ☐ Other(s):

☐ Current use of drugs or alcohol/recent drug use or heavy alcohol use in month prior to learning of pregnancy

☐ Late entry into prenatal care (>14 weeks)

☐ Hospital utilization in the antepartum period

☐ Missed 2+ prenatal appointments

☐ Cervical insufficiency

☐ Gestational diabetes

☐ Vaginal bleeding in 2nd trimester

☐ Hypertensive disorders of pregnancy

- ☐ Preeclampsia
- ☐ Gestational hypertension

☐ Short interpregnancy interval (<12 months between last live birth and current pregnancy)

☐ Current sexually transmitted infection

☐ Recurrent urinary tract infections (>2 in past six months, >5 in past two years)

☐ Non-English speaking

Primary language: _____

☐ Positive depression screening

Tool used: Score:

Obstetric history

☐ Preterm birth (<37 completed weeks)

Gestational age(s) of previous preterm birth(s):

_____weeks, _____weeks, _____weeks

☐ At least one spontaneous preterm labor and/or rupture of the membranes

*If this is a singleton gestation, this patient is eligible for 17P treatment.

☐ Low birth weight (<2,500 g)

☐ Fetal death >20 weeks

☐ Neonatal death (within first 28 days of life)

☐ Second trimester pregnancy loss

☐ Three or more first trimester pregnancy losses

☐ Cervical insufficiency

☐ Gestational diabetes

☐ Postpartum depression

☐ Hypertensive disorders of pregnancy

- ☐ Eclampsia
- ☐ Preeclampsia
- ☐ Gestational hypertension
- ☐ HELLP syndrome

☐ Provider request pregnancy care management reason(s)

Provider comments/notes:

Printed name of person completing form	Credential(s)	Signature

For OBCM Program only: Date RSF was received: _____ Date RSF was entered: _____

Pregnancy Medical Home Risk Screening Form

Complete this side of the form as honestly as possible and give it to your nurse or provider. The information you provide allows us to coordinate services with the pregnancy Care Manager and provide the best care for you and your baby.

Recipient information			
Name:		Date of birth:	Today's date:
Physical Address:		City:	ZIP code:
Mailing address (if different):		City:	ZIP code:
County:	Home phone number:	Work phone number:	
Cell:		Social Security number:	
Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black/African American ☐ Pacific Islander/Native Hawaiian ☐ White ☐ Other (specify):			
Ethnicity: ☐ Not Hispanic ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other Hispanic			
Education: ☐ Less than high school diploma ☐ GED or high school diploma ☐ Some college ☐ College graduate			

1. Thinking back to **just before you got pregnant**, how did you feel about becoming pregnant?
   - ☐ I wanted to be pregnant sooner
   - ☐ I wanted to be pregnant now
   - ☐ I wanted to be pregnant later
   - ☐ I did not want to be pregnant then or any time in the future
   - ☐ I don't know
2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐ **Yes** ☐ **No**
3. Are you in a relationship with a person who threatens or physically hurts you? ☐ **Yes** ☐ **No**
4. Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ **Yes** ☐ **No**
5. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food? ☐ **Yes** ☐ **No**
6. Is your living situation unsafe or unstable? ☐ **Yes** ☐ **No**
7. Which statement best describes your smoking status? Check one answer.
   - ☐ I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
   - ☐ I stopped smoking before I found out I was pregnant and am not smoking now.
   - ☐ I stopped smoking after I found out I was pregnant and am not smoking now.
   - ☐ I smoke now but have cut down some since I found out I was pregnant.
   - ☐ I smoke about the same amount now as I did before I found out I was pregnant.
8. Did any of your parents have a problem with alcohol or other drug use? ☐ **Yes** ☐ **No**
9. Do any of your friends have a problem with alcohol or other drug use? ☐ **Yes** ☐ **No**
10. Does your partner have a problem with alcohol or other drug use? ☐ **Yes** ☐ **No**
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? ☐ **Yes** ☐ **No**
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?
    ☐ **Not at all** ☐ **Rarely** ☐ **Sometimes** ☐ **Frequently**
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?
    ☐ **Not at all** ☐ **Rarely** ☐ **Sometimes** ☐ **Frequently**

(For pregnancy care management use only)

Date risk screening form was received: _____/_____/_____

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