

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
1-866-516-7224**

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

Completed by _____ Date _____

For Health Plan Use Only