

# 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
  - Preeclampsia
  - Oligohydramnios
  - Multiple gestation
  - Placenta previa

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# \_\_\_\_\_

Prescription is void if more than one (1) prescription is written per blank.

Completed by \_\_\_\_\_ Date \_\_\_\_\_

For Health Plan Use Only