BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

Maternal Health Risk Assessment

For questions about this form call: (800) 828-7514

Fax completed form to: (480) 760-4762

Date of 1st Prenatal Visit ________________

Please ATTACH A COPY OF THE PRENATAL RECORD

MEMBER INFORMATION

Name: ____ AHCCCS ID: ______________________________

Phone: ____ DOB: ____________________________ Age: ________

PROVIDER INFORMATION

Name: ____ NPI: ____

Phone: _______________________________________ Fax: ____

Contact Person: ________________________________ Extension: ___________________________________

US Facility___________________________________ US Facility NPI# ________________________________

CLINICAL INFORMATION

☐ WIC Referral Complete

LMP: __________ (☐ not known) EDD: ___________ (From ☐ LMP ☐ U/S) ☐ HIV Screening Complete

Date of entry into prenatal care: __________________ Date of first Visit in Provider's office: ________________

***Note: If all information below is found on the attached prenatal record, it is not necessary to continue.**

Pre-Pregnancy Weight: ___________ (☐ not known) Current Weight: ____________ Height: ____________

History	**Number** (indicate if none)		**Number** (indicate if none)
Total # Pregnancies:	_________	# Living Children	_________
# Deliveries after 37 0/7 weeks:	_________	# Miscarriages/Terminations:	_________
# Deliveries 32 0/7 – 36 6/7 weeks:	_________	# Cesarean deliveries:	_________
# Deliveries before 32 weeks:	_________	# VBAC deliveries:	_________

Condition (Check all that apply)	**Current**	**Prior**	**Condition** (Check all that apply)	**Current**	**Prior**
TWINS	☐	☐	PRETERM BIRTH	☐	☐
OTHER MULTIPLE_________	☐	☐	INCOMPETENT CERVIX	☐	☐
GESTATIONAL DIABETES	☐	☐	PLACENTA PREVIA	☐	☐
TYPE 1 or 2 DIABETES	☐	☐	PLACENTAL ABRUPTION	☐	☐
PIH / PRE-ECLAMPSIA	☐	☐	POST PARTUM HEMORRHAGE	☐	☐
ECLAMPSIA	☐	☐	SEIZURE DISORDER	☐	☐
CHRONIC HYPERTENSION	☐	☐	HEART DISEASE	☐	☐
FETAL ANOMALIES	☐	☐	RENAL DISEASE	☐	☐
GENETIC DISORDER	☐	☐	HEPATIC DISEASE	☐	☐
BEHAVIORAL HEALTH	☐	☐	INFECTIOUS DISEASE	☐	☐
DOMESTIC VIOLENCE	☐	☐	SUBSTANCE ABUSE	☐	☐
OTHER OBSTETRICAL COND	☐	☐	TOBACCO USE	☐	☐
OTHER MEDICAL CONDITIONS	☐	☐	HIV	☐	☐

If checked, please explain ____

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