

# Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink. Use the 'PRINT' button to print form and fax to: Aetna Better Health of Louisiana 1-866-776-2813.**

## Member Info

**\*required field**

Member ID\*

Last Name

First Name

Date of Birth (mmddyyyy)

Mailing Address

City

State

Zip

Home Phone

Cell Phone

Email Address

**Due Date\*** (mmddyyyy)

Preferred Language (if other than English)

Date of first Prenatal Visit (mmddyyyy)

Pre-pregnancy Weight

Race/Ethnicity (fill in all that apply) White

Black/African American

Hispanic/Latina

American Indian/Native American

Asian Hawaiian/Pacific Islander

Other

Please Specify

Number of Full Term Deliveries

Number of Stillbirths

Number of Pre-Term Deliveries

Number of Miscarriages/Abortions

## Pregnancy Risk Assessment

Are any of the following risk factors present? *\* If there are no known risk factors, Please fill in here*

### History (fill in all that apply):

Previous Pre-Term (<37 weeks) delivery?.....

If yes, was the delivery spontaneous?.....

Is the member a candidate for progesterone injections?...

Recent Delivery (within the past 12 months)?.....

Previous C -Section?.....

Diabetes (prior to pregnancy)?.....

Sickle Cell?.....

Asthma?.....

High Blood Pressure (prior to pregnancy)?.....

HIV Positive?.....

Seizure Disorder?.....

Seizure within the last 6 months?.....

Previous alcohol or drug abuse?.....

Date (mmddyyyy)

OB Provider Name:\*

TIN/ID number\*:

Mailing Address:

City:

State:

Zip Code:

This form was completed by:

Provider

Member

Member Rep

