OBSTETRICAL NEEDS ASSESSMENT FORM – INSTRUCTIONS FOR COMPLETION

This form is intended for Medicaid Recipients participating in a HealthChoices Voluntary or Mandatory Managed Care Organization (MCO), the ACCESS Plus Program or the Fee for Service delivery system.

This form serves as an MCO's or ACCESS Plus's/Fee for Service initial notification of a member's pregnancy. Its prompt submission from your office allows us to enroll our members in the maternity program as early as possible.

General Instructions (the form does not need to be completed by a physician)

1. Please do not leave any question or section blank; fill out all information completely.
2. For maximum accuracy, please use a black pen and print CAPITAL LETTERS, avoiding contact with the edges of the boxes.
3. Please place an "X" or check mark through the box. (Do NOT shade in the squares completely).
4. Please write only in designated areas. Do not cross out entry and write above the box.
5. Please attach additional information if necessary.
6. Use the same form for all visits (so you will not need to complete the top part each time).
7. Please fill in the demographics section in its entirety.

Dates to complete the sections of the form are:

Visit (Fax at these times)	Section to Complete
First prenatal visit	Top portion; Past OB Complications; Current Risks; Active Medical/Mental Health Conditions and Social, Economic, Lifestyle
28-32 week visit	Update all areas as needed, adding dates of prenatal visits thus far
Postpartum visit	Add postpartum information with date of visit and any additional visit dates as needed
New risk factors identified	Indicate on form where appropriate and fax form at any time during pregnancy

Complete the first section as follows (OB/GYN Office Information):	
Entry	Instructions/Reason to Provide Information
Practice name	Document the name of your practice or clinic
Phone # and Fax #	Document the phone number and fax number of practice or clinic
Provider MAID# (13-digits)	Document provider's individual/group identification # including address locator
Date initially faxed	Document date accordingly
28-32 week fax date	Document date accordingly
Postpartum (PP) fax date	Document date accordingly
Form Completed By	Document accordingly (This should be completed by healthcare professional)

Complete the first section as follows (Member's Information):	
First Name/Last Name	Document Member's full name
DOB	Document Member's date of birth
Age	Document Member's age at Expected Date of Confinement (EDC)
Mem ID/MAID#	Document MCO Member ID# or Medical Assistance ID#
Member Health Plan	Document whether Member belongs to ACCESS Plus, Aetna Better Health, AmeriHealth Mercy Health Plan, Coventry Cares, Fee for Service, Gateway Health Plan, Health Partners, Keystone Mercy Health Plan, United Healthcare, or UPMC for You
Healthy Beginnings Plus Member	Indicate whether Member is enrolled as Healthy Beginnings Plus Member
Home Phone/Alternate Phone	Document Member's home phone and alternate phone (if applicable)
Language(s)	List primary language and any secondary language(s) (if applicable)
Hospital for Delivery	Document Member's choice of hospital for delivery
1st Prenatal Visit	Date of first prenatal visit
EDC:	Expected date of confinement
By LMP of	Document if determined by last menstrual period and date of last menstrual period
By US, Date	Document if determined by ultrasound and date of ultrasound
GA at 1st Visit	Document gestational age at first prenatal visit
Gravida	Document Member's number of pregnancies
Full-term	Document number of pregnancies to full-term
Pre-term	Document number of pregnancies to pre-term
AB	Document number of abortions, if none indicate 0, DO NOT LEAVE BLANK
SAB	Document number of spontaneous abortions, if none indicate 0, DO NOT LEAVE BLANK
TAB	Document number of terminated abortions, if none indicate 0, DO NOT LEAVE BLANK

Living	Document number of living children, if none indicate 0, DO NOT LEAVE BLANK
Height/Weight/BMI	Document Member's height, weight and BMI
Date Last PAP	Document date of last Pap Smear
Date Last Chlamydia Screen	Document date of last Chlamydia screen
17P Candidate	Indicate whether Member is a candidate for 17P
Depression Screen	Document whether Member was screened for Depression
Validated Depression Tool	Document whether a validated depression tool was used. List the name of tool and date administered.
Result	Document whether Member screened positive or negative for Depression
Referral	Document whether Member was referred for treatment for Depression
Dental Visit, last 6 months	Document whether Member had a dental visit in the last 6 months

Complete the middle section as follows:

The information requested in the middle of the form allows the MCOs and ACCESS Plus to risk-stratify our members and to make appropriate referrals into our Case Management or Disease Management programs. The Current Risks and Active Medical/Mental Health Conditions sections have been expanded to better identify specific risks that could impact a pregnancy.

Entry	Instructions/Reason to Provide Information
Past OB Complications	Identifies members whose past complications increase their risk for current problems; If member has had no Past OB Complications, check No Past OB Complications box in section header.
Current Risks	Identifies potential risks for adverse outcomes; If member has had no Current Risks, check No Current Risks box in section header.
Active Medical/Mental Health Conditions	Identifies medical/mental health condition related to the mother; If member has had no Active Medical/Mental Health Conditions, check No Active Medical/Mental Health Conditions box in section header. For the following conditions, list specific disease type(s): Autoimmune, Cardiac, Hepatitis, Renal, Sickle Cell, STD, Thyroid. For all others, check Y/N.
Social, Economic, Lifestyle	Identifies lifestyle issues that can lead to adverse outcomes; If member has had no Social, Economic, Lifestyle indicators, check No Social, Economic, Lifestyle box in section header.
Delivery	Document date delivered, gestational age, elective delivery, delivered vaginal or c-section, delivered vertex, sex, birth weight (in grams), if baby was admitted to NICU, is the baby viable and if antenatal steroids were administered.
Postpartum Visit	Document the date of the visit, screen for post partum depression, if yes whether a validated depression tool was used, list the name of tool and date administered, and was referral made, feeding method, whether contraception discussed and plan, whether quit tobacco during pregnancy and whether remains tobacco free.
Prenatal Visit Dates	Complete for all visits after the first visit (first visit is already documented in the demographics section).
Attach additional information if necessary	

Questions regarding the form contact:

ACCESS Plus / Fee for Service
Attn: Maternity Program
100 Sterling Parkway, Suite 201
Mechanicsburg, PA 17050
Phone: 1-800-543-7633
Fax toll-free: 1-866-758-4745

Aetna Better Health
Special Needs Case Management
2000 Market Street, Suite 850
Philadelphia, PA 19103
Phone: 215-282-3596
Fax: 860-754-1325

AmeriHealth Mercy Health Plan
WeeCare Program
8040 Carlson Dr. Suite 500
Harrisburg, PA 17112
Phone: 1-877-693-8271, ext. 83570
Fax: 1-866-755-9935

Coventry Cares
3721 TechPort Drive
Harrisburg, PA 17111
Phone: 717-541-5927
Fax: 866-769-2401-confi & secure line

Gateway Health Plan
MOM Matters Program®
600 Grant Street
US Steel Tower, 41st Floor
Pittsburgh, PA 15219
Phone: 1-800-642-3550 - Option 2
Fax: 412-255-5639; Toll Free: 1-888-225-2360

Health Partners of Philadelphia
901 Market Street, Suite 500
Philadelphia, PA 19107
Phone: 215 967 4690
Fax: 215-967-4492

Keystone Mercy Health Plan
Maternity Program
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-800-521-6867, ext. 45711
Fax: 1-866-405-7946

United Healthcare for Families
Healthy First Steps
1001 Brinton Rd.
Pittsburgh, PA 15221
Phone: 800-599-5985
Fax: 877-353-6913

UPMC for You
Maternity Program
112 Washington Place
Chatham Two, 11th Floor
Pittsburgh, PA 15219
Phone: 866-778-6073
Fax: 412-454-8558

OBSTETRICAL NEEDS ASSESSMENT FORM (OBNAF)

OB/Gyn Office Information:

Practice Name | Phone | Fax | MAID

Date Initially Faxed | 28-32 Wks Fax Date | Postpartum Fax Date | Form Completed By

Member's Information:

First Name | Last Name | DOB | Age

Mem.ID/MAID# | Member's Health Plan | Healthy Beginnings Plus Member? ☐Yes ☐No | Home Phone

Alternate Phone | Language(s) | Hospital for Delivery | 1st Prenatal Visit

EDC | ☐by LMP of | ☐by US Date | GA at 1st Visit | Gravida | Full Term | Pre-Term

AB | SAB | TAB | Living | Height | Weight | BMI | Date/Last PAP | Date/Last Chlamydia Screen

17P Candidate? ☐Yes ☐No | Depression Screen? ☐Yes ☐No | Result: ☐Positive ☐Negative | Validated Depression Tool Used? List: | Date Admin: | Referral? ☐Yes ☐No

Dental Visit Last 6 Months? ☐Yes ☐No

Tobacco (Tob.) Use

Average # of Cigarettes Smoked/Day (If none, enter 0; 1 pack = 20 cigarettes)

Pre-Pregnancy | 1st Trimester | 2nd Trimester | 3rd Trimester

Tob. Counseling Offered? ☐Yes ☐No | Tob. Counseling Received? ☐Yes ☐No | Exposure to Environmental Smoke? ☐Yes ☐No | Counseling for Environmental Smoke? ☐Yes ☐No

Past OB Complications	Current Risks	1st	2nd	3rd
☐ No Past OB Complications	☐ No Current Risks			
☐ Postpartum Depression	☐ Hx Leep/Cone Biopsy			
☐ RH Incompatibility	Late and/or inconsistent prenatal care	☐	☐	☐
☐ Hx of DVT/PE	Abnormal Ultrasound	☐	☐	☐
☐ Gestational Diabetes	Abnormal Placenta:	☐	☐	☐
☐ Cervical Insufficiency	Gestational Diabetes	☐	☐	☐
☐ IUGR	2nd/3rd Trimester Bleeding		☐	☐
☐ Pregnancy Induced Hypertension (PIH)	Multiple Gestation ☐Yes ☐No			
☐ Premature ROM	Periodontal Disease	☐	☐	☐
☐ Preterm Labor/Delivery < 32 wks	Poor Weight Gain	☐	☐	☐
☐ Preterm Labor/Delivery 32 - 36 wks	IUGR	☐	☐	☐
☐ Fetal Demise/Hx 2nd/3rd Tri Loss	PIH	☐	☐	☐
☐ Previous C-Section #	Preterm Dilation of cervix/preterm labor	☐	☐	☐
Classical incision: ☐Yes ☐No	Previous delivery w/in 1 yr of EDC	☐	☐	☐
Prenatal Visits	**Social, Economic, Lifestyle**	**1st**	**2nd**	**3rd**
	☐ No Social, Economic, Lifestyle			
	Mental/Physical/Sexual Abuse ☐Hx	☐	☐	☐
	Intellectual Impairment	☐	☐	☐
	Homelessness	☐	☐	☐
	Eating Disorder:	☐	☐	☐
	Substance Abuse ☐ETOH ☐Hx	☐	☐	☐
	☐Rx ☐Hx	☐	☐	☐
	☐Street ☐Hx	☐	☐	☐
	Opioid Therapy	☐	☐	☐

Active Medical/Mental Health Conditions	Yes	No
☐ No Active Medical/Mental Health Conditions		
Autoimmune Disease(s):	☐	☐
Anemia Hb < 10	☐	☐
Asthma	☐	☐
Cardiac Disease:	☐	☐
Chronic Hypertension, Pregestational	☐	☐
Diabetes, Pregestational	☐	☐
Hepatitis:	☐	☐
HIV	☐	☐
Schizophrenia	☐	☐
Renal Disease:	☐	☐
Seizure Disorder	☐	☐
Sickle Cell Disease: ☐Trait ☐Disease	☐	☐
☐ Depression ☐ Bipolar	☐	☐
STD:	☐	☐
Thyroid: Treated: ☐Yes ☐No	☐	☐

Other Conditions:

Delivery: Date | at ☐Gestation | Elective Del. ☐Yes ☐No

☐Vag ☐C/S Vertex ☐Yes ☐No Birth Wgt:

☐NCIU Admission Viable: ☐Yes ☐No | Antenatal Steroids ☐Yes ☐No

Postpartum Visit (Between 21-56 days after delivery)

Visit | Feeding Method: ☐Breast ☐Bottle ☐Both

PP Contraception Discussed: ☐Yes ☐No | Contraception Plan

PP Depression Present: ☐Yes ☐No

Validated Depression Tool Used? List: | Date Admin:

Referral: ☐Yes ☐No

Quit Tob. During Preg. ☐Y ☐N Remains Tob. Free ☐Y ☐N

Physician Signature

Date Signed

pennsylvania
DEPARTMENT OF PUBLIC WELFARE
www.dpw.state.pa.us