

\*Practice Name: \_\_\_\_\_

Practice Phone Number: \_\_\_\_\_

\*Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of next prenatal appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

First name: \_\_\_\_\_ MI \_\_\_\_\_ Last name: \_\_\_\_\_

\*EDC: \_\_\_\_/\_\_\_\_/\_\_\_\_ Determined by what criteria:  LMP  1st trimester U/S  2nd trimester U/S

Height: \_\_\_\_ft \_\_\_\_in Pre-pregnancy weight: \_\_\_\_\_ Gravidity: \_\_\_\_\_ Parity: \_\_\_\_\_T\_\_\_\_\_P\_\_\_\_\_A\_\_\_\_\_L

Insurance type:  Medicaid (includes Presumptive)  Private  None

Medicaid ID#: \_\_\_\_\_ PHP Name: \_\_\_\_\_

\*CURRENT PREGNANCY

- Multifetal Gestation
 Fetal complications:
 Fetal anomaly
 Fetal chromosomal abnormality
 Intrauterine growth restriction (IUGR)
 Oligohydramnios
 Polyhydramnios
 Other(s): \_\_\_\_\_
 Chronic condition which may complicate pregnancy:
 Diabetes
 Hypertension
 Asthma
 Mental illness
 HIV
 Seizure disorder
 Renal disease
 Systemic lupus erythematosus
 Other(s): \_\_\_\_\_
 Current use of drugs or alcohol/recent drug use or heavy alcohol use in month prior to learning of pregnancy
 Late entry into prenatal care (>14 weeks)
 Hospital utilization in the antepartum period
 Missed 2+ prenatal appointments
 Cervical insufficiency
 Gestational diabetes
 Vaginal bleeding in 2nd trimester
 Hypertensive disorders of pregnancy
 Preeclampsia
 Gestational hypertension
 Short interpregnancy interval (<12 months between last live birth and current pregnancy)
 Current sexually transmitted infection
 Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
 Non-English speaking
Primary language: \_\_\_\_\_
 Positive depression screening
o Tool used: \_\_\_\_\_
o Score = \_\_\_\_\_

\*OBSTETRIC HISTORY

- Preterm birth (<37 completed weeks)
Gestational age(s) of previous preterm birth(s):
\_\_\_\_weeks, \_\_\_\_weeks, \_\_\_\_weeks
 At least one spontaneous preterm labor and/or rupture of the membranes
\*If this is a singleton gestation, this patient is eligible for 17P treatment.

- Low birth weight (<2500g)
 Fetal death >20 weeks
 Neonatal death (within first 28 days of life)
 Second trimester pregnancy loss
 Three or more first trimester pregnancy losses
 Cervical insufficiency
 Gestational diabetes
 Postpartum depression
 Hypertensive disorders of pregnancy
 Eclampsia
 Preeclampsia
 Gestational hypertension
 HELLP syndrome

Provider requests care management

Reason(s): \_\_\_\_\_

Provider Comments/Notes: \_\_\_\_\_

\*Person Completing Form: \_\_\_\_\_

\*Credentials: \_\_\_\_\_

\*Signature: \_\_\_\_\_

For LHD Use Only: Date RSF was received: \_\_\_\_\_

\*Date RSF was entered: \_\_\_\_\_

\*Required fields

# Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Complete this side of the form as honestly as possible and give it to your nurse or doctor. The information you provide allows us to coordinate services with the care manager and provide the best care for you and your baby.

Name: _____	Date of birth: _____	Today's date: _____
Physical Address: _____	City: _____	ZIP: _____
Mailing Address (if different): _____	City: _____	ZIP: _____
County: _____	Home phone number: _____	Work phone number: _____
Cell phone number: _____	Social security number (if available): _____	
Race: <input type="checkbox"/> American-Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African-American
<input type="checkbox"/> Pacific Islander/Native Hawaiian	<input type="checkbox"/> White	<input type="checkbox"/> Other (specify): _____
Ethnicity: <input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Cuban	<input type="checkbox"/> Mexican
<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Other Hispanic	
Education: <input type="checkbox"/> Less than high school diploma	<input type="checkbox"/> GED or high school diploma	<input type="checkbox"/> Some college
<input type="checkbox"/> College graduate		

- Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
  - I wanted to be pregnant sooner
  - I wanted to be pregnant now
  - I wanted to be pregnant later
  - I did not want to be pregnant then or any time in the future
  - I don't know
- Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?  Yes  No
- Are you in a relationship with a person who threatens or physically hurts you?  Yes  No
- Has anyone forced you to have sexual activities that made you feel uncomfortable?  Yes  No
- In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food?  Yes  No
- Is your living situation unsafe or unstable?  Yes  No
- Which statement best describes your smoking status? Check one answer.
  - I have never smoked, or have smoked less than 100 cigarettes in my lifetime
  - I stopped smoking BEFORE I found out I was pregnant and am not smoking now
  - I stopped smoking AFTER I found out I was pregnant and am not smoking now
  - I smoke now but have cut down some since I found out I was pregnant
  - I smoke about the same amount now as I did before I found out I was pregnant
- Did any of your parents have a problem with alcohol or other drug use?  Yes  No
- Do any of your friends have a problem with alcohol or other drug use?  Yes  No
- Does your partner have a problem with alcohol or other drug use?  Yes  No
- In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?  Yes  No
- Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?  
 Not at all     Rarely     Sometimes     Frequently
- In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?  
 Not at all     Rarely     Sometimes     Frequently

\*Required fields

Version 2 (Rev. 12/01/2020) Submit completed form to the CMHRP staff at the local health department in the patient's county of residence.