AETNA BETTER HEALTH® OF VIRGINIA

Maternity Notification and Risk Screen

Please complete this form during the first prenatal visit for all Aetna Better Health of Virginia members, then fax to **1-959-333-2203** or email to AetnaBetterHealthofVAHealthyBabies@aetna.com. If you have questions or would like to speak to an OB care manager, please call 1-800-279-1878.

Member name: ____ **Member ID:** ________________________________

Address (Street/Apt. #): ________________________________ **City/state/ZIP:** ______________________________

Day phone: _____________________ **Evening phone:** ___________________ **Cell phone:** _____________________

Email: ____ **Date of birth:** _____________________

Practice name: ____ **Provider:** ___________________________________

Practice address: ____ **Contact person:** __________________________

Phone: ____________________________ **Fax:** ____________________________

Planned hospital/birthing center: _______________________________ **G** _____ **P** _____ **T** _____ **PT** _____ **A** _____

SAB: 1st trimester/2nd trimester ☐ _____________ **EAB**: 1st trimester/2nd trimester ☐ _____________

Delivery method (planned): VBAC ☐ C-section ☐ Vaginal delivery ☐

EDC: _______/______/______ **LMP:** _______/______/______ **Date of first prenatal visit:** ______/_____/_____

Enrolled in WIC? Yes ☐ No ☐ **Lead testing on mother?** Yes ☐ No ☐ **Depression screening done?** Yes ☐ No ☐

Height: _____ feet ______ inches **Pre-pregnancy weight**: ______________ **Current weight:** ______________

Name of Pediatrician: ____

Previous Pregnancy Complications
(Check all that apply)

☐ No previous complications
☐ Gestational diabetes
☐ Fetal demise >23 weeks gestation
☐ Incompetent cervix
☐ GBS
☐ PIH
☐ Cerclage
☐ Recurring pregnancy loss
☐ Premature rupture of membranes
☐ Neonatal Abstinence Syndrome
☐ Preterm birth - Weeks gestation
☐ Preterm labor
☐ Other: ______________________

Medical History Risk Factors
(Check all that apply)

☐ None apply to this member
☐ RH factor
☐ Hypertension
☐ Diabetes: Diet? ________ Medication? ________
☐ Asthma
☐ History of or current STD
☐ History of seizure disorder
☐ Sickle cell
☐ Coagulation disorder
Medication: ☐ Coumadin ☐ Lovenox ☐ Heparin
☐ DES exposure
☐ Chlamydia screening

Proprietary

Other Risk Factors
(Check all that apply)

☐ None apply to this member
☐ Alcohol
☐ Other drug abuse
☐ Tobacco use
☐ Domestic violence
☐ Pica
☐ Anemia
☐ Noncompliance
☐ Mental illness
☐ Family support
☐ Anorexia
☐ Bulimia

Feelings about pregnancy: Happy ☐ Unhappy ☐ Anxious ☐ Unknown ☐

Current Pregnancy
(Check all that apply)

☐ None apply to this member
☐ Asthma
☐ Fetal anomaly
☐ Hypothyroidism
☐ Hyperemesis
☐ Multiple gestation
☐ Preterm labor
☐ Positive fetal fibronectin test
☐ Infertility treatment
☐ Diabetes
☐ Hypertension
☐ Uterine or cervical anomaly
☐ IUGR
☐ Placental abruption/previa
☐ Makena candidate (contact care manager: 1-800-279-1878)
☐ Progesterone treatment
☐ Cervical cerclage: Current ☐ Planned ☐

Planned feeding method: Unknown ☐ Breast ☐ Bottle ☐

Current Pregnancy
(Check all that apply)

☐ None apply to this member
☐ Prescription (please list):
☐ Over the counter (please list):

Provider signature: ____ **Date**: _________________________

OB Timeframe Reminder

- 1st prenatal care visits should be during the 1st trimester or within 42 days of enrollment with Aetna Better Health of Virginia
- Postpartum follow-up visits must occur between 21 and 56 days after delivery (C-section incision check only does not count as a postpartum visit)

Please fax both sides of this form to 1-959-333-2203 or email it to AetnaBetterHealthofVAHealthyBabies@aetna.com