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* | y* | |
|---|--|--|-------------------|--------------------------------------|--|
| Last Name | First Name | | | | |
| Date of Birth (mmddyyy) | Mailing Ad | dress | | | |
| City | | State | Zip | | |
| Home Phone | Cell Phone | | | | |
| Email Address | | Centin | JIK . | | |
| Due Date* (mmddyyyy) | Preferred | Language (| if other than Enc | nelish) | |
| Date of first Prenatal Visit (mmddyyyy) | Preferred Language (if other than English) Pre-pregnancy Weight | | | | |
| | D11- / A C-: A | | | , | |
| Race/Ethnicity (fill in all that apply) White | Black/African Ame | | Hispanic/Lati | tina American Indian/Native American | |
| Asian Hawaiian/Pacific Islander | Other Please S | . , | | | |
| Number of Full Term Deliveries | | r of Stillbirt | | | |
| Number of Pre-Term Deliveries | Number | r of Miscarı | riages/Aborti | tions | |
| Pregnancy Risk Assessment ——— | | | | | |
| Are any of the following risk factors preser | nt? * If there are no l | anown risl | k factors, P | Please fill in here | |
| History (fill in all that apply | | | | ancy (fill in all that apply): | |
| Previous Pre-Term (<37 weeks) delivery?. | •••••• | Pre-Term | labor this pre | regnancy? | |
| If yes, was the delivery spontaneous? | | Shortened Cervix <23 weeks this pregnancy? | | | |
| Is the member a candidate for progesteron | e injections? | Length | | | |
| Recent Delivery (within the past 12 month | hs)? | Cervical C | erclage placei | ement? | |
| Previous C -Section? | •••••• | Twins? | Triple | lets? Discordant? | |
| Diabetes (prior to pregnancy)? | | Shortened Cervix <23 weeks this pregnancy? Length Cervical Cerclage placement? Twins? Triplets? Discordant? Current severe hyperemesis? Current mental health concerns? | | | |
| Sickle Cell? | | Current m | ental health c | concerns? | |
| Asthma? | •••••• | List | | | |
| High Blood Pressure (prior to pregnancy)? | ······ | Current S7 | ГD? | List | |
| HIV Positive? | •••••• | Current to | bacco use? | Amount | |
| Seizure Disorder? | •••••• | Current ald | cohol use? | Amount | |
| Seizure within the last 6 months? | | Current str | eet drug use? | ? | |
| Previous alcohol or drug abuse? | •••••• | | | | |
| Date (mmddyyyy) | | | | | |
| OB Provider Name:* | | | | | |
| TIN/ID number*: | Pł | none Numb | er: | | |
| Mailing Address: | | | | | |
| City: | | Sta | ıte: | Zip Code: | |

This form was completed by:

Provider

Member

Member Rep