Notification of Pregnancy Form

sunflower health plan | Start Smart for Your Baby® | KanCare

***Required Field**

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 and fax to: 1-866-681-5125.**

MEMBER INFO

Member ID* _____ DOB* (mmddyyyy) _____

Last Name* _____ First Name* _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Primary Insurance (for mom or baby) other than Medicaid? Yes ◯ No ◯

Due Date* (mmddyyyy) _____ Date of last Chlamydia Screening (mmddyyyy): _____

Date of first Prenatal Visit (mmddyyyy) _____ Date of last Pap Smear (mmddyyyy): _____

Race/Ethnicity (Mark each box with a thick **X**)

White ☐ Black/African American ☐ Hispanic/Latina ☐ American Indian/Native American ☐

Asian ☐ Hawaiian/Pacific Islander ☐ Other ☐ Please specify _____

Preferred Language (if other than English) _____

Number of Full Term Deliveries _____ Number of Stillbirths _____

Number of Preterm Deliveries _____ Enrolled in WIC? Yes ◯ No ◯

Number of Miscarriages/Abortions Planning to breastfeed? Yes ◯ No ◯

Height ☐' ☐" Pre-Pregnancy Weight _____ Pre-Pregnancy BMI _____

PREGNANCY RISK ASSESSMENT

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

History (place a thick X for all that apply):

Previous Preterm (<37 weeks) delivery? ☐

If yes, was the delivery spontaneous? ☐

Currently on 17P? ☐

Recent delivery (within past 12 months)? ☐

(within past 6 months)? ☐

Previous C-Section? ☐

Previous severe preeclampsia? ☐

Diabetes (prior to pregnancy)? ☐

Sickle Cell? ☐

Asthma? ☐

Worse symptoms during pregnancy? ☐

Current Pregnancy (place a thick X for all that apply):

Preterm labor this pregnancy? ☐

Current placenta previa? ☐

Vaginal bleeding after 14 weeks? ☐

Shortened Cervix < 23 weeks this pregnancy? ☐

Length _____

Current gestational diabetes? ☐

Current preeclampsia? ☐

Current oligohydramnios? ☐

Twins? ☐ Triplets? ☐ Discordant? ☐

Current fetal growth restriction? ☐

Current congenital anomalies? ☐

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Last Name*

First Name*

DOB* (mmddyyyy)

History (place a thick X for all that apply):

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

Well controlled? .....

Previous neonatal death or stillborn?.....

Associated with maternal health condition?.....

HIV positive? HIV negative? Testing refused?

AIDS? .....

Seizure disorder? .....

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

Previous alcohol or drug abuse? .....

Current Pregnancy (place a thick X for all that apply):

BMI <20 or poor weight gain this pregnancy? .....

UTI/Pyelo/Bacteriuria this pregnancy? .....

Current severe hyperemesis?.....

Current mental health concerns?.....

List

Current STD? List

Current tobacco use? Amount

Current alcohol use? Amount

Current street drug use?.....

Any social needs? Yes No Please list below.

Other Significant Risk Factors Yes No Please list below.

Date (mmddyyyy)

OB Provider Name*

TIN/ID Number* Phone Number

Mailing Address

City State Zip Code

If you would like your patient to receive a free 3 month supply of prenatal vitamins, please complete the Prenatal Vitamin Form. For any questions regarding this form or the Start Smart program, please call 1-877-644-4623.