PRENATAL REGISTRATION

PRENATAL REGISTRATION FORM

MVP Health Care Little Footprints℠
MVP Health Care, 220 Alexander Street, Rochester, NY 14607
Please fax to: 585-327-5759

Date Completed: _____

Demographics

Patient Name: _____ **DOB:** _____ **Insurance Name:** _____

Current Address: _____ **Member ID:** _____

City, State: _____ **Zip:** _____

Phone: _____ **EDC:** _____ **Diagnosis:** _____ □ **Normal Pregnancy** □ **High Risk Pregnancy**

G:_____**P:**_____ **Registered for Prenatal Care:**_____ **Weeks by LMP/Ultrasound:**_____

Race: □ **African American** □ **Caucasian** □ **Latino/Hispanic** □ **Asian/Pacific Islander** □ **Non-White/Other** □ **Other** _____

Billing Information

Primary Prenatal Care Provider:_____ **Group NPI Number:** _____

MD Phone:_____ **Hospital (for delivery):** _____

Date of First Prenatal Visit:_____ □ **First Trimester** □ **Second Trimester** □ **Third Trimester**

I	**Social Risk Factors:**
	Automatic Referral if 4 or more risk factors from this category or for active domestic violence
	☐ No Phone ☐ Primary Language:_____ ☐ Unemployed/DSS > 1 yr. ☐ Limited Social Support Network ☐ Lives Alone ☐ Unstable Living Arrangement ☐ No Family Support ☐ Transportation: Problem with Keeping Appointments ☐ Secondary Smoke in Residence ☐ History of Physical/Sexual Abuse: Is this a current problem? ☐ Yes ☐ No
	For II, III, and IV, Automatic Referral if 5 or more risk factors identified from all three categories combined
II	**Maternal Medical History:**
	☐ DVT/Pulmonary Embolism ☐ Hx. Pyelonephritis ☐ Primary Hypertension ☐ Hx. DES Exposure ☐ Diabetes Mellitus ☐ Asthma/COPD ☐ Current Cigarette Use ☐ Dental Care - Within Last Year ☐ Yes ☐No ☐ Hx. STD's ☐ Any Dental Problems: _____
III	**Psycho-Neurological History:**
	Automatic referral if desires counseling, current substance abuse or mentally/physically challenged
	☐ Clinical/Post Part. Depression ☐ Suicide Attempt ☐ Takes Medication for Mental Illness ☐ Previous Counseling Evaluation or Treatment, For How Long?_____ ☐ Desires Counseling Referral ☐ Substance/Alcohol Abuse Hx ☐ Current Use? List Substance: _____ ☐ Mentally/Physically Challenged: _____
IV	**Maternal Obstetrical History:**
	Automatic Referral for any history or current PTL or <12 months between births
	☐ Current PTL ☐ Hx. PTL and/or Use of 17P ☐ Previous Uterine Surgery, Describe: _____ ☐ Hx. Gestational Diabetes ☐ Tocolytics used @_____weeks gestation ☐ Pregnancy Induced Hypertension ☐ Abruptio Placenta ☐ Eating Disorder, List:_____ ☐ Placenta Previa ☐ Pre-Eclampsia ☐<12 Months Between Births
V	**Previous Infant/Findings:**
	Automatic Referral for any history of preterm birth or stillbirth
	☐ Stillbirth >28 weeks ☐ Birth weight <2500 Gms. ☐ Other _____ ☐ Preterm birth <30 weeks ☐ Preterm Birth 30-36 Weeks ☐ Birth weight >4000 Gms.

Please list any other medical/psychological problems not included above or other issues which may place this patient at risk in pregnancy: _____

_____

_____

Provider Completing Form (Please Print):_____ **Title:** _____

MD Signature:_____ **Date:** _____

Community Agencies Involved: _____