

Maternal Child Health Risk Assessment  
Request for Total OB Authorization



Call the stork line: (800) 828-7514  
Fax in the Completed Request: (480) 317-3358

**\*REQUIRED TO BE FILLED IN**

\*Date of Request: \_\_\_\_\_ \*Ordering Provider: \_\_\_\_\_  
\*Member Name: \_\_\_\_\_ \*Provider NPI: \_\_\_\_\_  
\*AHCCS ID: \_\_\_\_\_ \*Phone #: \_\_\_\_\_  
\*Member Phone: \_\_\_\_\_ \*Fax #: \_\_\_\_\_  
\*DOB: \_\_\_\_\_ \*Age: \_\_\_\_\_ \*Contact in Office: \_\_\_\_\_

\*U/S Facility: \_\_\_\_\_ Facility NPI #: \_\_\_\_\_

\*Date of Entry into Prenatal Care: \_\_\_\_\_ \*Date of First Visit in your Office: \_\_\_\_\_  
Provider Change, Reason for Provider Change: \_\_\_\_\_

\*High Risk: Explain: \_\_\_\_\_

**\*ICD-9 DIAGNOSIS:** \_\_\_\_\_

*Note: ICD-9 Required, FAILURE TO PROVIDE MAY DELAY PROCESSING*

\*LMP: \_\_\_\_\_ Pre-Pregnancy Weight: \_\_\_\_\_ Last Pap Smear: \_\_\_\_\_  
\*EDC : \_\_\_\_\_ Current Weight: \_\_\_\_\_  WIC Referral Complete  
\*G: \_\_\_\_\_ \*P: \_\_\_\_\_ Height: \_\_\_\_\_  HIV Screening Complete

**Current Pregnancy:**

Multiple Pregnancy?  Twins  Triplets  Other, Explain: \_\_\_\_\_

PTL/Cervical Incompetence  Diabetes/Gestational Diabetes  Fetal Anomalies  Other

If any checked, please explain: \_\_\_\_\_

\*Other specialist currently involved in members care?  Yes  No Specialist: \_\_\_\_\_

Reason: \_\_\_\_\_

**Pregnancy History:**

\*Miscarriages: \_\_\_\_\_ \*Terminations: \_\_\_\_\_ \*VBACs: \_\_\_\_\_

\*Vaginal Deliveries: \_\_\_\_\_ C-Sections: \_\_\_\_\_

PTL/Cervical Incompetence  Diabetes/Gestational Diabetes  Fetal Anomalies  Other

If any checked, Please Explain: \_\_\_\_\_

**\*CURRENT Medical Information:**

Neurological  Gastrointestinal  Renal  Cardiovascular  HIV  Endocrine

If any checked, Please explain: \_\_\_\_\_

Are these conditions affecting the member's Pregnancy?  Yes  No

If yes, please explain: \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

Current STD: \_\_\_\_\_ Treatment: \_\_\_\_\_ Partner Treated:  Yes  No

**Other:**

Behavioral Health  Domestic Violence  Substance Abuse  Smoker  Other

If any checked, please explain: \_\_\_\_\_

TOB Authorization: _____	Date Span: _____ to _____
Date Issued: _____	HCA Staff Completed: _____