



# TOTAL OB PRE-AUTHORIZATION

## Maternal Health Risk Assessment

For questions about this form call: (800) 828-7514

Fax completed form to: (480) 760-4762

Date of Request: \_\_\_\_\_

Please ATTACH A COPY OF THE PRENATAL RECORD

### MEMBER INFORMATION

Name: \_\_\_\_\_ AHCCCS ID: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

### PROVIDER INFORMATION

Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Extension: \_\_\_\_\_

US Facility \_\_\_\_\_ US Facility NPI# \_\_\_\_\_

### CLINICAL INFORMATION

WIC Referral Complete

LMP: \_\_\_\_\_ ( not known) EDD: \_\_\_\_\_ (From  LMP  U/S)  HIV Screening Complete

Date of entry into prenatal care: \_\_\_\_\_ Date of first Visit in Provider's office: \_\_\_\_\_

**\*Note: If all information below is found on the attached prenatal record, it is not necessary to continue.**

Pre-Pregnancy Weight: \_\_\_\_\_ ( not known) Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

#### History

Number (indicate if none)

Number (indicate if none)

Total # Pregnancies: \_\_\_\_\_

# Living Children \_\_\_\_\_

# Deliveries after 37 0/7 weeks: \_\_\_\_\_

# Miscarriages/Terminations: \_\_\_\_\_

# Deliveries 32 0/7 – 36 6/7 weeks: \_\_\_\_\_

# Cesarean deliveries: \_\_\_\_\_

# Deliveries before 32 weeks: \_\_\_\_\_

# VBAC deliveries: \_\_\_\_\_

**Condition** (Check all that apply) **Current** **Prior**

TWINS

OTHER MULTIPLE \_\_\_\_\_

GESTATIONAL DIABETES

TYPE 1 or 2 DIABETES

PIH / PRE-ECLAMPSIA

ECLAMPSIA

CHRONIC HYPERTENSION

FETAL ANOMALIES

GENETIC DISORDER

BEHAVIORAL HEALTH

DOMESTIC VIOLENCE

OTHER OBSTETRICAL COND

OTHER MEDICAL CONDITIONS

**Condition** (Check all that apply) **Current** **Prior**

PRETERM BIRTH

INCOMPETENT CERVIX

PLACENTA PREVIA

PLACENTAL ABRUPTION

POST PARTUM HEMORRHAGE

SEIZURE DISORDER

HEART DISEASE

RENAL DISEASE

HEPATIC DISEASE

INFECTIOUS DISEASE

SUBSTANCE ABUSE

TOBACCO USE

HIV

If checked, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_