Minnesota Obstetrical Risk Assessment form

Health care professional information			Member ID number: _____
Last name:	First name:	Middle initial:	DOB (mm/dd/yyyy):
Address:			
City, state, ZIP code:		Telephone number:	
Email:	Date of initial prenatal visit/diagnosis date:	Completion date of pregnancy:	

Pregnancy information and history

LMP	Gestational age at first visit	EDC	Gravida	Para	Pre-term	Living	Abortions	
							Spontaneous:	Induced:
_____	_____	_____	_____	_____	_____	_____	_____	_____

Risk factors (past or current)

- ☐ No risk factors
- ☐ Diabetes/GDM/LGA baby
- ☐ DVT/PT
- ☐ Eclampsia/pre-eclampsia
- ☐ Fetal congenital anomaly or disorder
- ☐ Fetal death
  - ☐ 2nd trimester ☐ 3rd trimester
- ☐ Hypertension/GHTN
- ☐ Incompetent cervix
- ☐ IUGR/SGA baby
- ☐ Late and/or inconsistent prenatal care
- ☐ Low birth weight < 2500 grams
- ☐ Multiple gestation
- ☐ Placenta abnormalities
  - ☐ Abruption ☐ Previa
- ☐ Premature ROM
- ☐ Pre-term (specify gestational age)
  - ☐ Delivery: _____
  - ☐ Labor: _____
- ☐ Renal disease
- ☐ Sickle cell disease/trait
- ☐ Abnormal ultrasound: _____
- ☐ Uterine abnormality: _____
- ☐ Other: _____

Active medical conditions

- ☐ None
- ☐ Advanced maternal age
- ☐ Asthma
- ☐ Auto-immune disease(s)

_____

- ☐ BMI (low or high): _____
- ☐ Hepatitis
- ☐ HIV
- ☐ Seizure disorder: _____

Thyroid disease — treated?

- ☐ Yes ☐ No
- ☐ Other (specify): _____

Social, economic and lifestyle factors

- ☐ No risk factors
- ☐ Behavioral health condition

_____

- ☐ Domestic violence
- ☐ Housing issues
- ☐ Identified social, economic and lifestyle

_____

- ☐ Intellectual impairment
- ☐ Lack of support system
- ☐ Literacy issues
- ☐ Mental/physical/sexual abuse (current or history of): _____

_____

- ☐ Postpartum depression
- ☐ Smoking/vaping/tobacco use; individualized intervention offered?
  - ☐ Yes ☐ No
- ☐ Substance use:
  - ☐ Alcohol: _____
  - ☐ Drug: _____
- ☐ Teen pregnancy: _____
- ☐ Other (specify): _____

STI history				Current medications
	Screen date:	Negative	Positive	☐ No medications
☐ HIV:	_____	☐	☐	Please list: _____
☐ Syphilis:	_____	☐	☐	_____
☐ Gonorrhea:	_____	☐	☐	_____
☐ Chlamydia:	_____	☐	☐	_____

Provider information		
Provider name:		Tax ID number:
Phone number:	Fax number:	Delivery hospital:
Address:	City, state, ZIP code:	

Provider requesting care coordination? ☐ Yes ☐ No

Provider (MD/DO/APRN/PA): _____ Date: _____

Please complete and fax the enclosed form for each of your pregnant patients who are UnitedHealthcare Community Plan members within 15 calendar days of the member's first prenatal visit. Please fax each form to **877-353-6913**.

United Healthcare Community Plan