Obstetrical Authorization & Initial Assessment

Amerigroup District of Columbia, Inc.
Phone: 800-454-3730 Fax: 800-964-3627

Submission Date:

Health Plan:

Provider Name:

NPI or Provider Number:

Phone Number: Fax Number:

Member Information

First Name | MI | Last Name

Member ID or MA Recipient No. | Date of Birth *(MM/DD/YYYY)* | Age | Home Phone | Alternate Phone | 1st Prenatal Visit *(MM/DD/YYYY)*

Primary Language ***NOT*** English | Language Spoken *(if not English)* | EDC *(MM/DD/YYYY)* | BMI | Gestational Age *(weeks)* | Gravida | Para | TAB | Live Births

Hospital/Birthing Center for Delivery

☐ HUH ☐ Providence ☐ UMC ☐ WHC ☐ GWUH ☐ Other: Specify:

Past OB Complications/Current Risk Factors

HIV screening date *(MM/DD/YYYY):*_____ *Not Applicable - HIV+* ☐

Check all that apply (P=Past Pregnancy C=Current Pregnancy)

Medications: ☐

P	C		P	C	
☐	☐	17 - P Administration	☐	☐	Incompetent cervix
☐	☐	Abnormal Placenta	☐	☐	Infant or Child death
☐	☐	Anemia Hb <10	☐	☐	Late/missed prenatal care
☐	☐	Asthma	☐	☐	Multiple gestation
☐	☐	Autoimmune Disease	☐	☐	Oral Problems:
☐	☐	Bleeding: 1st ☐ 2nd ☐ 3rd ☐	☐	☐	Preeclampsia/Eclampsia
☐	☐	Cardiac:	☐	☐	Pregnancy induced hypertension
☐	☐	Cervical cerclage	☐	☐	Premature ROM
☐	☐	Chronic hypertension, pregestational	☐	☐	Preterm delivery
☐	☐	Clotting disorder:	☐	☐	Preterm labor: <32W ☐ 32-36W ☐
☐	☐	Dental visit >6 mos?	☐	☐	Previous C-Section
☐	☐	Depression/Mental Health	☐	☐	Previous delivery within1 year
☐	☐	Diabetes, pregestational	☐	☐	Previous LBW (<2,500 gms)
☐	☐	Disability:	☐	☐	Renal disease
☐	☐	Eating disorder:	☐	☐	Seizure disorder:
☐	☐	Ectopic pregnancy	☐	☐	Sickle cell: Trait ☐ Disease ☐
☐	☐	Elective Delivery <39 weeks	☐	☐	STI:
☐	☐	Fetal loss: 1st ☐ 2nd ☐ 3rd ☐	☐	☐	Substance Use (alcohol, tobacco, drugs)
☐	☐	Gestational diabetes	☐	☐	Thyroid disease
☐	☐	Hepatitis:	☐	☐	Weight gain or loss challenges

Late Entry Into Prenatal Care

(First prenatal visit after 1st trimester)

Check all that apply:

- ☐ Lack of health insurance
- ☐ Unaware of the importance of prenatal care
- ☐ Childcare issues
- ☐ Unable to find a health provider
- ☐ Unsure of keeping pregnancy to term
- ☐ Financial problems
- ☐ Unable to get an appointment in the first trimester
- ☐ Other (*specify)*:

OTHER HEALTH AND SOCIAL NEEDS *(please answer all questions below)*

You, Your Family and Partner

- ☐ Do you have children in your home or under your care? How many? ☐
- ☐ Is your partner involved with your pregnancy?
- ☐ Is your husband or partner employed?
- ☐ Are you employed?
- ☐ Do you feel that you have enough help from your family or friends to care for your new baby?
- ☐ If you could change the timing of this baby would you want to?
- ☐ Did you consider adoption or abortion at any point during this pregnancy?
- ☐ Are you currently in foster care?
- ☐ Has CFSA been involved with any of your children?
- ☐ Are you currently working with a case manager, therapist, or counselor?
- ☐ Have you seen a probation officer in the last 12 months?
- ☐ Do you worry about getting food when you need it or getting good quality food?
- ☐ Do you currently receive WIC benefits?
- ☐ Do you currently receive food stamps/EBT?

Transportation, Housing and Environmental Exposures

- ☐ Have you moved in the last 3 months? How often? ☐
- ☐ Are you homeless or worry that you could become homeless soon?
- ☐ Have any of your children had a positive blood test for lead?
- ☐ Do you have pets? What Kind? Cat ☐ Bird ☐
  Other: _____
- ☐ Do you have cockroaches and rodents in your home?
- ☐ Does anyone in your household smoke?
- ☐ Are there any leaks or mold in your home?
- ☐ Do you have any problems getting to doctor visits or appointments?

Domestic Violence (ACOG 3-Question Screen)

- ☐ Within the past year, or since you have been pregnant, have you be hit, slapped, kicked, or otherwise physically hurt by someone?
- ☐ Are you in a relationship with someone who threatens or physically hurts you?
- ☐ Has anyone forced you to have sexual activities that made you feel uncomfortable?

4 Ps Plus©

- ☐ Did either of your parents have a problem with drugs or alcohol?
- ☐ Does your partner have any problem with drugs or alcohol?
- ☐ Have you ever felt manipulated by your partner?
- ☐ Have you ever felt out of control or helpless?

Over the past 2 weeks:

- ☐ Have you felt down, depressed, or hopeless?
- ☐ Have you felt little interest or pleasure in doing things?

In the ***month before*** you knew you were pregnant:

About how many cigarettes did you smoke per week?
☐ None ☐ Less than ½ pack ☐ About 1 pack ☐ More than 1 pack

How many days per week did you drink beer/wine/liquor?
☐ None ☐ Less than 1 ☐ 1-2 ☐ 3-6 ☐ Everyday

How many days per week did you use marijuana, cocaine or heroin?
☐ None ☐ Less than 1 ☐ 1-2 ☐ 3-6 ☐ Everyday

And ***now***:

About how many cigarettes do you smoke per week?
☐ None ☐ Less than ½ pack ☐ About 1 pack ☐ More than 1 pack

How many days per week do you drink beer/wine/liquor?
☐ None ☐ Less than 1 ☐ 1-2 ☐ 3-6 ☐ Everyday

How many days per week do you use marijuana, cocaine or heroin?
☐ None ☐ Less than 1 ☐ 1-2 ☐ 3-6 ☐ Everyday

Referrals: *Referral completed (C) - check left box; Referral Needed (N) - check right box)*

C	N		C	N	
☐	☐	APRA/Substance Abuse Program	☐	☐	Non-Obstetric Specialty Medical Care
☐	☐	Domestic Violence Services	☐	☐	Nutritional Counseling/Nutritionist
☐	☐	High Risk OB/Maternal Fetal Medicine	☐	☐	Oral Health/Dental Services
☐	☐	Home Environment Assessment	☐	☐	Out of Plan Services Provider: _____
☐	☐	Home Visiting Agency	☐	☐	Smoking Cessation Hotline/Services
☐	☐	Genetics	☐	☐	Social Work
☐	☐	MCO Care Coordination/Case Management:	☐	☐	Support and Education Group: _____
		Reason: _____	☐	☐	Teen Pregnancy Services
☐	☐	Mental Health:	☐	☐	WIC
		Reason: _____	☐	☐	Other (specify): _____

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