Notification of Pregnancy Form
Fax completed form to (select one):

[ ] Anthem 855-325-5453
[ ] Children's Community Plan 414-266-4726
[ ] GHC of South Central Wisconsin 608-662-4907
[ ] iCare 414-231-1090 Attn: Bao Xiong
[ ] MHS Health WI 866-671-3668
[ ] MercyCare 608-752-3751
[ ] Molina 877-708-2117
[ ] My Choice Wisconsin **(SSI)** 608-210-4050 Attn: HPCM Clinical Team
[ ] My Choice Wisconsin **(BC)** 414-771-1159
[ ] UnitedHealthcare Community Plan 877-353-6913

Member Information

Last Name:_____ First Name: _____ DOB: _____ ID#: _____

Address:_____ City: _____ Zip: _____ Phone #: _____

Date of Initial Prenatal Visit:_____ Completion date of Pregnancy Form:_____

Current Pregnancy

In PNCC _____

Gravida _____ Para_____ LMP_____ EDC_____ Blood Type _____

Multiple Gestation this pregnancy **Maternal age ≤ 16 years** Maternal age ≥ 35 years of age

Previous Pregnancies (Check all that apply)

Hx of Placenta Pre
Multiple Gestations previous pregnancy
Hx of Post Partum Depression
Preterm Labor/Delivery
Hx of SAB/TAB/Fetal Demise
Previous C-Section
Week of delivery _____
Week of demise _____

Medical History (Check all that apply)

Cardiac Disease
Clotting Disorders
Hypertension or PIH (Current/Past)
Respiratory Conditions
Behavioral Health Concerns
Incompetent cervix (Current/Past)
HIV Status
STD (Current/Past)
Neurologic Disorders (Current/Past)
Sickle Cell Anemia
Diabetes/Gestational Diabetes (Current/Past)

Psycho/Social Issues (check all that apply)

Drug Abuse(Current/Past)
Alcohol Abuse (Current/Past)
Smoker (Current/Past)
Domestic Abuse (Current/Past)
Housing Issues
Lack of Support System

Prenatal Care and Nutrition (Check all that apply)

Missed several medical appointments
Currently Enrolled in WIC

Description of above or other unlisted conditions: _____

_____

List of Medications: _____

_____

Provider Information

_____ _____
Provider Signature Provider Printed Name

_____ _____
Provider Address Provider Phone #

_____ _____
Delivery Hospital Provider Fax #