



AUTHORIZATION/PREGNANCY RISK ASSESSMENT

Date: _____

Phone 602.778.1800 x1830 Fax 602.778.1838

PROVIDER INFORMATION

| | |
|-------------------|---|
| Physician Name: | Fax: |
| Street Address: | Office Contact: |
| City, State, ZIP: | Contact Phone: |
| Phone: | Date of 1 st visit in your office: |

MEMBER INFORMATION

| | | | |
|--------------------------|--|-------------|------|
| Member Name: | WIC Referral: | | |
| Member ID: | <input type="checkbox"/> High Risk: Why: _____ | | |
| Street Address: | LMP: | Weeks: | EDC: |
| City, State, Zip: | Weight Now: | Pre – Preg: | |
| Phone Number: | Date of Birth: | Age: | |
| Primary Language Spoken: | Other Insurance: | | |

PREGNANCY HISTORY (circle or fill in the blank with number)

How many pregnancies? 1 2 3 4 5 _____ Multiple Pregnancy: Twins Triplets Other
 Number of living children? 1 2 3 4 5 _____ Induced abortions: _____
 Premature Labor: _____ Premature Deliveries: _____ Miscarriages: _____
 Vaginal deliveries: _____ C/Sections: _____ Why? _____
 Smoke? Yes No How much? _____ Drink Alcohol? Yes No How Much? _____
 Street Drugs: Yes No _____
 All Current Medications: _____
 Medication Allergies? Yes No _____
 Any problems with pregnancy? _____
 Any Problems with Previous Pregnancies? _____
 Significant social history? _____

MEDICAL PROBLEMS

Heart Lung Kidneys Diabetes Asthma High Blood Pressure
 Other _____
 Previous Surgeries: _____
 Any previous HIV exposure or history? Has HIV status been confirmed with labwork? _____
 Any History of STD's? _____
 Received prenatal care prior to filling out this form? _____
 If yes, from whom? _____
 Hospital for delivery: _____

CARE 1ST HEALTH PLAN ARIZONA USE ONLY

| | | |
|---|-------------|--------|
| Authorization #: _____ | From: _____ | Dates: |
| Completed By: _____ | To: _____ | |
| Care 1st Health Plan Arizona notes: _____ | | |
| _____ | | |

Submit the Pregnancy Risk Assessment Form within thirty (30) days from the initial visit. If not submitted within a timely, authorization may be considered for visits only. Please complete the form in its entirety. If you have questions, call our Maternal Child Health (MCH) Team at 602.778.1800 x 8336. The risk assessment form is used by Case Management for assessment of member needs and risks for a complicated pregnancy.