Maternity Initial Risk Evaluation

Total Questions : **25**

Member Details :

Name: | **Altruista ID:**

Date Of Birth: | **Home Phone:**

1 Does the member or legal guardian give verbal permission to discuss PHI?

- Yes
- No

2 Are you currently pregnant?

- Yes
- No - Referral made in error, member delivered in the last 6 months
- No - Referral made in error, member not pregnant in the last 6 months
- Declines to answer

3 What is your due date?

Select date from the calendar

4 What is the best phone number to reach you at?

Enter phone number

5 Do you have an obstetrician or other OB care provider?

- Yes-Add provider to external care team
- No

  Do you need assistance selecting a provider?

  - Yes-Add provider to external care team
  - No

6 Have you attended or scheduled your first prenatal appointment with a doctor?

- Yes

  Select date from calendar

- No

  Do you need assistance scheduling an appointment

  - Yes
  - No

7 Are you experiencing any of the symptoms related to your pregnancy? If so please notify your doctor. They may want to see you or may direct you to an emergency room. Check all that apply.

- Abdominal cramping
- Vaginal bleeding
- Excess thirst
- Persistent low back pain
- Severe or constant headaches
- Swelling of hands or face
- Vaginal discharge other than bleeding
- Visual disturbances
- Weakness/dizzy/fainting

- [ ] None

8 How many times have you been pregnant before?

- ( ) 0- This is my first pregnancy
- ( ) 1
- ( ) 2
- ( ) 3 or more
- ( ) N/A

9 If pregnant before, were any of your other children delivered before 37 weeks (premature) or were they born weighing less than 5.5 lbs (low birth weight)?

- ( ) Yes
- ( ) No
- ( ) N/A
- ( ) Unsure

10 Were any of your other children admitted to the NICU?

- ( ) Yes
- ( ) No
- ( ) N/A
- ( ) Unsure

11 Have you ever been told you have one or more of the following conditions in this or a past pregnancy? Check all that apply.

- [ ] Pregnancy losses?

  Three or more pregnancy losses?

  ( ) Yes ( ) No

- [ ] Preterm labor

  Current or past pregnancy?

  ( ) Current ( ) Past

- [ ] Hypertension or high blood pressure

  Current or past pregnancy?

  ( ) Current ( ) Past

- [ ] Gestational Diabetes- high blood sugar

  Current or past pregnancy?

  ( ) Current ( ) Past

- [ ] Depression or Post Partum depression

  Current or past pregnancy?

  ( ) Current ( ) Past

- [ ] Problems with cervix

  Current or past pregnancy?

  ( ) Current ( ) Past

- [ ] Problems with placenta

  Current or past pregnancy?

- Current
- Past

- Bleeding after the first 3 months

  Current or past pregnancy?

  - Current
  - Past

- Multiple gestation-Twins etc

  Current or past pregnancy?

  - Current
  - Past

- Genetic defects or syndromes

  Current or past pregnancy?

  - Current
  - Past

- Clotting problems

  Current or past pregnancy?

  - Current
  - Past

- None

12 Do you currently see a doctor for any of the following conditions? Select all that apply

- Asthma
- Depression
- Other mental health condition
- Heart disease
- HIV/AIDS
- Other sexually transmitted infection
- Hypertension/High blood pressure
- Kidney disease
- Liver disease
- Seizures/Other neurological condition
- Sickle Cell Disease
- Terminal illness
- Transplant condition
- Substance use treatment

  Are you in treatment?

  - Currently in treatment
  - Need referral for treatment
  - Have been treated in the past
  - Not interested in treatment at this time

- Other maternity specialist
- None

13 Do you currently use tobacco or nicotine products (cigarettes, chewing tobacco, cigars, pipes, smokeless tobacco, electronic cigarettes)?

- Yes

  Would you like information about resources to help quit smoking?

  - Yes-offer local resources
  - No

- No

14 Have you had an overnight hospital stay during this pregnancy?

- Yes

  What was the reason? [ ]

- No

15 Have you been to the ER during this pregnancy?

- Yes

  What was the reason? [ ]

- No

16 During the past year were you ever unable to pay for or had to do without any of the following: Select all that apply. Provide member with resources. Check all that apply. Provide member with resources.

- Food
- Medicine
- Water/Electricity/Heat/Other Utility
- Housing
- None

17 Do you have any concerns about being safe in your home, your neighborhood, or your personal relationships?

- Yes-Give resources to make referrals
- No

18 Do you need additional resources for you or your baby, things like a crib, diapers, a car seat etc.? Select all that apply and note resources/referrals given to member.

- Breastfeeding supplies, breast pump, bottles
- Car Seat
- Cell phones/MyHealth Line (if available in market)
- Childcare for other children
- Crib
- Clothes
- Community pregnancy support programs
- Diapers
- Text 4 Babies
- Transportation for doctor visits
- WIC/Supplemental Nutrition Program referral
- Other

  Please specify [ ]

- None

19 Your health plan offers a program that will give you rewards for going to your doctor. It's called Baby Blocks. Can I help you enroll in Baby Blocks? Need to verify plan benefit first.

- Yes
- Already enrolled
- Declined

- N/A

20 Would you like to become pregnant in the year after you deliver your baby?

- Yes- Talk with your doctor about having a healthy pregnancy
- No- Talk to your doctor about birth control options

21 Have you selected a pediatrician for your baby?

- Yes- Note pediatrician in notes
- No- Offer assistance in selecting provider and note selection in notes

22 Do you understand process and time frame in your state to enroll your baby in Medicaid coverage?

- Yes
- No

23 Note: Total Risk Score. Any score 1 or greater- enroll member into High Risk Pregnancy program.

Select next question

24 Note: All pregnant members also require PHQ 2/9 assessment AND AUDIT-C for adults OR CRAFFT for teens. Any positive screen for any of these assessments also requires member to be placed in High Risk Pregnancy program regardless of score on this assessment

Select next question

25 End Assessment

Frayne DJ et al. Health care system measures to advance preconception wellness: Consensus recommendations of the Clinical Workgroup of the National Preconception Health and Health Care Initiative. Obstet Gynecol 2016 May; 127:863.
Copyright ©2018 UnitedHealth Group. All Rights Reserved. Any use, copying, or distribution without written permission from UnitedHealth Group is prohibited.