

Maternity Risk Screening Form

Name _____ DOB ____ / ____ / ____ Marital Status _____

Beneficiary Address: _____ Telephone Number ____ / ____ / ____

Social Security No: _____ Medicaid No: _____

Education: Check highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12 13+

Negative Risk screen date ____ / ____ / ____ Positive Risk screen date ____ / ____ / ____

First Prenatal Visit with any provider ____ / ____ / ____ EDC: ____ / ____ / ____

Provider Referred To: _____ Appointment Date ____ / ____ / ____

Provider Address: _____ Provider Telephone Number ____ / ____ / ____

Provider Signature: _____

Instructions on reverse side

RISK FACTORS AFFECTING CURRENT & PAST PREGNANCIES

<u>Specify w/4th or 5th digit (if applicable)</u>	<u>Specify w/4th or 5th digit (if applicable)</u>
<input type="checkbox"/> 640. ___ Threatened abortion <input type="checkbox"/> 648. ___ Diabetes <input type="checkbox"/> 642. ___ HTN affecting pregnancy and/or childbirth <input type="checkbox"/> 278.01 Morbid Obesity <input type="checkbox"/> 795.71 Infection, HIV <input type="checkbox"/> 641. ___ Placenta previa <input type="checkbox"/> 643. ___ Hyperemesis <input type="checkbox"/> 645. ___ Late Pregnancy(≥40 weeks gestation) <input type="checkbox"/> 647. ___ Infectious/parasitic conditions of the mother <input type="checkbox"/> 646. ___ Insufficient weight gain. ≤ 5lbs @ 20 Weeks or ≤10 lbs @ 30 weeks <input type="checkbox"/> 648.20 ___ Anemia ≤ 30 HCT 10/HGB <input type="checkbox"/> 651. ___ Multiple gestation	<input type="checkbox"/> 653. ___ <input type="checkbox"/> 654. ___ Disproportion and/or abnormality of Organs and pelvis soft tissue <input type="checkbox"/> 655. ___ <input type="checkbox"/> 656. ___ Known or suspected fetal or placental abnormalities <input type="checkbox"/> 657. ___ <input type="checkbox"/> 658. ___ Polyhydramnios and/or other problems affecting amniotic cavity membranes <p><u>Check one</u></p> <input type="checkbox"/> V23.2 Habitual abortion, fetal death no intervening Pregnancy <input type="checkbox"/> V23.5 EDC ≤ 14 months after previous delivery <input type="checkbox"/> V23.7 Insufficient / no prenatal care / late to care <input type="checkbox"/> V23.81 Age ≥ 40 Primigravida <input type="checkbox"/> V23.82 Age ≥ 40 Multigravida <input type="checkbox"/> V23.83 Young ≤ 16 Primigravida <input type="checkbox"/> V23.84 Young ≤ 16 Multigravida <input type="checkbox"/> V23.89 Premature Labor <input type="checkbox"/> V60.0 Homeless

Maternity Risk Screening Form

Purpose:

- ❖ The Maternity Risk Screening Form is designed to screen pregnant women who are at high risk for preterm delivery and poor pregnancy outcome into the PHRM/ISS Program.

Instructions:

- ❖ Demographic information for pregnant women screened
 - Enter the name, telephone number, date of birth, address, Social Security number, Medicaid number and marital status.
 - Circle the highest grade completed at the time of delivery. For any education completed beyond high school, circle “13+”.
 - Enter the date of the first prenatal visit if any or enter 00/00/00 if no prenatal care was obtained.
 - Enter the estimated date of confinement.
- ❖ Screen outcome:
 - Enter the positive screen or negative screen date.
 - Enter the name, telephone number and appointment date of the referring PHRM/ISS case management agency.
 - The provider (physician, physician assistant, nurse practitioner or nurse midwife) performing the risk screening will sign the form using his/her professional title, telephone number and address.
 - Bill using: T1023-TH Maternal Medical Risk Screening and the ICD-9 code of one of the most significant risk factor(s) checked on the screening form.

Office Mechanics and Filing:

- ❖ Positive risk screens:
 - The original is to be filed in the pregnant woman’s chart and be retained as a permanent part of the record. A positive risk screen should be mailed to the referring PHRM/ISS case management agency.
- ❖ Negative risk screens:
 - The form is to be kept in the pregnant woman’s record and filled out when risk factors develop and then processed in the manner described above.

Retention Period:

- ❖ This form is part of the medical record and must be retained according to agency policy