



TOTAL OB PRE-AUTHORIZATION

Maternal Health Risk Assessment

For questions about this form call: (800) 828-7514

Fax completed form to: (480) 760-4762

Date of Request: _____

Please ATTACH A COPY OF THE PRENATAL RECORD

MEMBER INFORMATION

Name: _____ AHCCCS ID: _____

Phone: _____ DOB: _____ Age: _____

PROVIDER INFORMATION

Name: _____ NPI: _____

Phone: _____ Fax: _____

Contact Person: _____ Extension: _____

US Facility _____ US Facility NPI# _____

CLINICAL INFORMATION

WIC Referral Complete

LMP: _____ (not known) EDD: _____ (From LMP U/S) HIV Screening Complete

Date of entry into prenatal care: _____ Date of first Visit in Provider's office: _____

***Note: If all information below is found on the attached prenatal record, it is not necessary to continue.**

Pre-Pregnancy Weight: _____ (not known) Current Weight: _____ Height: _____

History

Number (indicate if none)

Number (indicate if none)

Total # Pregnancies: _____

Living Children _____

Deliveries after 37 0/7 weeks: _____

Miscarriages/Terminations: _____

Deliveries 32 0/7 – 36 6/7 weeks: _____

Cesarean deliveries: _____

Deliveries before 32 weeks: _____

VBAC deliveries: _____

Condition (Check all that apply) **Current** **Prior**

TWINS

OTHER MULTIPLE _____

GESTATIONAL DIABETES

TYPE 1 or 2 DIABETES

PIH / PRE-ECLAMPSIA

ECLAMPSIA

CHRONIC HYPERTENSION

FETAL ANOMALIES

GENETIC DISORDER

BEHAVIORAL HEALTH

DOMESTIC VIOLENCE

OTHER OBSTETRICAL COND

OTHER MEDICAL CONDITIONS

Condition (Check all that apply) **Current** **Prior**

PRETERM BIRTH

INCOMPETENT CERVIX

PLACENTA PREVIA

PLACENTAL ABRUPTION

POST PARTUM HEMORRHAGE

SEIZURE DISORDER

HEART DISEASE

RENAL DISEASE

HEPATIC DISEASE

INFECTIOUS DISEASE

SUBSTANCE ABUSE

TOBACCO USE

HIV

If checked, please explain _____
