High-Risk Pregnancy Referral Form

For provider use only.

Please complete this form for all CalViva Health members with high-risk pregnancies within 7 days of identification. Fax form to secure fax line at (866) 878-0034. For questions, call (559) 447-6122.

SECTION A: Patient Information

Today's date (MM/DD/YY): _____ID card #/CIN #: _____Date of birth (MM/DD/YY): _____

Last name: _____First name: _____Telephone #: _____

Street address: _____City: _____State: _____ZIP code: _____

Date of last menstrual period: _____Anticipated delivery hospital:_____ Due date (MM/DD/YY): _____

Preferred language spoken: ☐ English ☐ Spanish ☐ Other: _____

Race/ethnicity: ☐ Hispanic/Latino ☐ African American ☐ Asian/Pacific Islander ☐ White ☐ Native American ☐ Other:_____

SECTION B: OB Provider Information

Last name: _____ First name: _____

Street address: _____ Suite #: _____ City: _____ State: _____ ZIP code: _____

Telephone #: _____Tax ID: _____Provider license #: _____

SECTION C: Current Medications

List all current medications:

☐ Prenatal vitamins ☐ Insulin/diabetic medication ☐ Blood pressure medication:_____

☐ Narcotics ☐ Antidepressant/anti-anxiety ☐ Other: _____

SECTION D: Identified Risk

Medical:

☐ Asthma ☐ Currently receiving 17-p injections ☐ Current placental problems

☐ Diabetes ☐ Gestational diabetes ☐ Previous preterm birth (<37 weeks)

☐ Advanced maternal age (>35 years) ☐ Genetic disorder ☐ Previous high-risk pregnancy

☐ History of poor pregnancy outcome ☐ Multifetal pregnancies ☐ Pregnancy-induced hypertension

☐ Stillbirth ☐ Multiple miscarriages ☐ LBW or VLBW

☐ Medications that may affect fetal outcome ☐ Teen pregnancy (<17 years) ☐ Other: _____

Substance Abuse:

☐ Alcohol How many drinks per day?_____ ☐ Tobacco/cigarettes Packs per day? _____

☐ Prescription medications used Name of medication:_____ How often? _____

☐ Street drugs ☐ Marijuana ☐ Other What drug(s)?_____ How often? _____

List any other medical/psychological problems not included above or other issues that may place member at risk:

_____

SECTION E: Referrals Made by OB Office or CPSP Program (indicate location or name of the program)

☐ WIC ☐ Case management_____ ☐ Health plan:_____ ☐ Nutrition counseling_____

☐ Prenatal/parenting/childbirth classes_____ ☐ Glucose monitor with nutritional counseling _____

☐ Smoking cessation_____ ☐ Substance abuse treatment_____ ☐ Psychosocial services_____

Provider comments or suggestions:

_____

_____

Signature and Title: _____ **Date:**_____

To be completed by internal case manager:

DATE CM OPENED: _____ **DATE DELIVERED:** _____ **DATE CM CLOSED:** _____