HEALTH NET
MEDI-CAL PROGRAM
PERINATAL NOTIFICATION and ASSESSMENT REPORT

Section A *Basic Information*

Date:
Member Name:
AKA:
Member ID #:
Date of Birth:
Address: City: State: CA Zip: Phone: ( )
Marital Status — Circle One: Single Married Sep Dv Unk
Language
Years of Education — 0 1 2 3 4 5 6 7 8 9 10 11 12 12+
EDC — LMP
Grav: Para: Sab: Tab:
Date Pregnancy Verified:
Date of First Prenatal Care Visit:
OB Provider:
Address City: State: CA Zip:
OB Telephone #: ( )
OB Office Contact:
Comments:

Section B *Risk Assessment Data*

High Risk Condition *(check if applies)*	**YES**	**NO**
Maternal age 17 years or less		
Maternal age 35 years or more		
Maternal medical or surgical condition		
High blood pressure		
Asthma		
Diabetes		
Physical disabilities (speech, hearing, or vision)		
Genetic disroder(s)		
Eating disorder		
Severe anemia		
Prior hx of PIH (Preg Induced Hypertension)		
Previous pre-term deliveries		
Prior infant/fetal demise		
Hx of C-Section		
Cervical conditions: hx cone biopsy or cerclage		
Placental conditions If yes, what?_____		
Gestational Diabetes		
Referral for Diabetic Care:		
Multigestational pregnancy		
Socioeconomic factors which may require referral (Please explain in comments)		
Evidence of family violence		
Psychological conditions		
Noncompliance with therapies or interventions		
Current tobacco use pks/day_____		
Current alcohol use How much?_____		
Substance use		
If yes, name substances(s):		

Section C *Additional Assessment Report*

Is OB/Gyn CPSP Yes ☐ No ☐ CPSP Offered: Yes ☐ No ☐ Enrolled: Yes: ☐ No ☐ If no, why?_____	VBAC offered: If Hx of prior C/S Yes ☐ No ☐ If no, why not?_____
CPSP services referred to_____	Baby Dr. options provided Yes ☐ No ☐
HIV test offered: Yes ☐ No ☐ WIC offered: Yes ☐ No ☐	Birth control options discussed Yes ☐ No ☐
Plans to breastfeed Yes ☐ No ☐	Method desired (please circle) ☐BTL ☐Oral BCP ☐Depo ☐Other

Section D *Postpartum*

Date of Visit: Postpartum complications: Yes ☐ No ☐	Current birth control method
Tye of complication:	Bonding issues? Yes ☐ No ☐

Please FAX to Perinatal Care Manger within 7 days of first prenatal visit and after each reassessment: (800) 315-4123

Basic Information: ☐ 2nd Trimester ☐
3rd Trimester: ☐ PostPartum: ☐

hcs/periform 1/19/99