

**HEALTH NET
MEDI-CAL PROGRAM
PERINATAL NOTIFICATION and ASSESSMENT REPORT**

Section A Basic Information

Section B Risk Assessment Data

Date:		High Risk Condition (check if applies)	YES	NO
Member Name:		Maternal age 17 years or less		
AKA:		Maternal age 35 years or more		
Member ID #:		Maternal medical or surgical condition		
Date of Birth:		High blood pressure		
Address:		Asthma		
City: State: CA Zip:		Diabetes		
Phone: ()		Physical disabilities (speech, hearing, or vision)		
Marital Status	Circle One: Single Married Sep Dv Unk	Genetic disorder(s)		
Language		Eating disorder		
Years of Education	0 1 2 3 4 5 6 7 8 9 10 11 12 12+	Severe anemia		
EDC	LMP	Prior hx of PIH (Preg Induced Hypertension)		
Grav: Para: Sab: Tab:		Previous pre-term deliveries		
Date Pregnancy Verified:		Prior infant/fetal demise		
Date of First Prenatal Care Visit:		Hx of C-Section		
OB Provider:		Cervical conditions: hx cone biopsy or cerclage		
Address		Placental conditions If yes, what? _____		
City: State: CA Zip:		Gestational Diabetes		
OB Telephone #: ()		Referral for Diabetic Care		
OB Office Contact:		Multigestational pregnancy		
Comments:		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 <input type="checkbox"/> No <input type="checkbox"/>	VBAC offered: If Hx of prior C/S Yes <input type="checkbox"/> No <input type="checkbox"/>
CPSP Offered: Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, why not? _____
Enrolled: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, why? _____	Baby Dr. options provided Yes <input type="checkbox"/> No <input type="checkbox"/>
CPSP services referred to _____	Birth control options discussed Yes <input type="checkbox"/> No <input type="checkbox"/>
HIV test offered: Yes <input type="checkbox"/> No <input type="checkbox"/> WIC offered: Yes <input type="checkbox"/> No <input type="checkbox"/>	Method desired (please circle) BTL Oral BCP Depo Other
Plans to breastfeed Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section D Postpartum

Date of Visit: Postpartum complications: Yes <input type="checkbox"/> No <input type="checkbox"/>	Current birth control method:
Type of complication	Bonding issues? Yes <input type="checkbox"/> No <input type="checkbox"/>

Please FAX to Perinatal Care Manger within 7 days of first prenatal visit and after each reassessment: (559) 447-6178

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