Community Health Plan OF IMPERIAL VALLEY   health net

High-Risk Pregnancy Referral Form

For provider use only.

Please complete this form for all Community Health Plan of Imperial Valley members with high-risk pregnancies within 7 days of identification. Fax form to secure fax line at 866-81-0540. For questions, email CASHP.ACM.CMA@healthnet.com.

SECTION A: Patient Information

Today's date (MM/DD/YY): ____________ ID card #/CIN #: ______________________ Date of birth (MM/DD/YY): ____________

Last name: ____________________________ First name: ________________________ Phone #: _____________________

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: _________

Phone #: _______________________ 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:

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____

Signature and Title: ____ **Date:** ________________

To be completed by internal case manager:

DATE CM OPENED: _______________ **DATE DELIVERED:** _____________ **DATE CM CLOSED:** _____________