



AETNA BETTER HEALTH® OF VIRGINIA

Maternity Notification and Risk Screen

Please complete this form during the first prenatal visit for all Aetna Better Health of Virginia members, then fax to **1-959-333-2203** or email to **AetnaBetterHealthofVAHealthyBabies@Aetna.com**. If you have questions or would like to speak to an OB care manager (CM), please call **1-800-279-1878**.

Member name: _____	Member ID: _____	
Address (Street/Apt. #): _____	City/state/ZIP: _____	
Day phone: _____	Evening phone: _____	Cell phone: _____
Email: _____	Date of birth: _____	
Practice name: _____	Provider: _____	
Practice address: _____	Contact person: _____	
Phone: _____	Fax: _____	
Planned hospital/birthing center: _____	G ____ P ____ T ____ PT ____ A ____	
SAB: 1st trimester/2nd trimester <input type="checkbox"/> _____	EAB: 1st trimester/2nd trimester <input type="checkbox"/> _____	
Delivery method (planned): VBAC <input type="checkbox"/> C-section <input type="checkbox"/> Vaginal delivery <input type="checkbox"/>		
EDC: ____/____/____	LMP: ____/____/____	Date of first prenatal visit: ____/____/____
Enrolled in WIC? Yes <input type="checkbox"/> No <input type="checkbox"/>	Lead testing on mother? Yes <input type="checkbox"/> No <input type="checkbox"/>	Depression screening completed? Yes <input type="checkbox"/> No <input type="checkbox"/>
Height: ____ feet ____ inches	Pre-pregnancy weight: _____	Current weight: _____
Name of Pediatrician: _____		
Previous Pregnancy Complications (Check all that apply)		
<input type="checkbox"/> No previous complications	<input type="checkbox"/> Recurring pregnancy loss	
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Premature rupture of membranes	
<input type="checkbox"/> Fetal demise >23 weeks gestation	<input type="checkbox"/> Neonatal Abstinence Syndrome	
<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Preterm birth - Weeks gestation	
<input type="checkbox"/> GBS	<input type="checkbox"/> Preterm labor	
<input type="checkbox"/> PIH	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Cerclage		

**Medical History Risk Factors
(Check all that apply)**

- | | |
|--|---|
| <input type="checkbox"/> None apply to this member | <input type="checkbox"/> History of seizure disorder |
| <input type="checkbox"/> RH factor | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Coagulation disorder |
| <input type="checkbox"/> Diabetes: Diet? _____ Medication? _____ | Medication: <input type="checkbox"/> Coumadin <input type="checkbox"/> Lovenox <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> DES exposure |
| <input type="checkbox"/> History of or current STD | <input type="checkbox"/> Chlamydia screening |

**Other Risk Factors
(Check all that apply)**

- | | |
|--|---|
| <input type="checkbox"/> None apply to this member | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Noncompliance |
| <input type="checkbox"/> Other drug abuse | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Family support |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Pica | <input type="checkbox"/> Bulimia |
- Feelings about pregnancy: Happy Unhappy Anxious Unknown

**Current Pregnancy
(Check all that apply)**

- | | |
|--|---|
| <input type="checkbox"/> None apply to this member | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Fetal anomaly | <input type="checkbox"/> Uterine or cervical anomaly |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> IUGR |
| <input type="checkbox"/> Hyperemesis | <input type="checkbox"/> Placental abruption/previa |
| <input type="checkbox"/> Multiple gestation | <input type="checkbox"/> Makena candidate (call CM: 1-800-279-1878) |
| <input type="checkbox"/> Preterm labor | <input type="checkbox"/> Progesterone treatment |
| <input type="checkbox"/> Positive fetal fibronectin test | <input type="checkbox"/> Cervical cerclage: Current <input type="checkbox"/> Planned <input type="checkbox"/> |
| <input type="checkbox"/> Infertility treatment | |
- Planned feeding method: Unknown Breast Bottle

**Current Pregnancy
(Check all that apply)**

- Prescription (please list):
 Over the counter (please list):
 None apply to this member

Provider signature: _____

Date: _____

OB Timeframe Reminder

- 1st prenatal care visits should be during the first trimester or within 42 days of enrollment with Aetna Better Health of Virginia
- Postpartum follow-up visits must occur between 21 and 56 days after delivery (C-section incision check only does not count as a postpartum visit)

**Please fax both sides of this form to 1-959-333-2203 or email it to
AetnaBetterHealthofVAHealthyBabies@aetna.com**