



OB REGISTRATION

Complete and return this form for all new obstetrical patients.

Information used by care management teams to coordinate care and education.

Please provide as much information as possible.

Phone: (888) 251-3063 Fax: (804) 819-5186 / (866) 284-1057 (Cent. VA/ Fred/Western)

Phone: (800) 828-7989 Fax: (757) 466-1133 (Tidewater)

Phone: (888) 338-4579 Fax: (540) 344-8007 / (800) 827-7192 (Roanoke)

DATE

/ /

Virginia Premier Health Plan, Inc.

PATIENT INFORMATION

PATIENT NAME		AGE	DATE OF BIRTH / /	ID#
ADDRESS (Number, street, Apt #, Zip)				PATIENT'S PHONE
PCP	OBSTETRICIAN		OBSTETRICIAN'S PHONE	

PATIENT HISTORY

CURRENT WEIGHT	PRE-PREGNANY WEIGHT	HEIGHT	LAST MENSTRUAL PERIOD	SONOGRAM PERFORMED
DATE PRENATAL CARE INITIATED		GRAVIDA: LIVE BIRTHS:	PARA: ECTOPIC:	EDC

RISK ASSESSMENT

<p>Yes NO</p> <p>Planned C-Section Indication: _____</p> <p>Smoker Substance Abuse If YES, list: _____</p> <p>HIV / AIDS STD If YES, list: _____</p> <p>IUGR Incompetent Cervix Other: _____</p> <p>Do you consider this High Risk Pregnancy If YES, list: _____</p>	<p>PREVIOUS ADVERSE PREGNANCY OUTCOMES</p> <p>Premature Births Stillbirths Fetal Death Fetal Abnormalities Fetal Complications Abortion Other _____</p>
	<p>CURRENT PREGNANCY COMPLICATIONS</p> <p>Maternal Bleeding Preeclampsia Diabetes Hypertension Nutritional Deficit Other _____</p>

ADDITIONAL COMMENTS:

INSTRUCTIONS: At initial visit, complete PATIENT INFORMATION and PATIENT HISTORY for ALL pregnant members. Send copy to Virginia Premier Health Plan, Inc.