

EXHIBIT A



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

ADDITIONAL COMMENTS:

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