

# Obstetrical Needs Assessment Form

Please fax this form to AmeriHealth Caritas New Hampshire at **1-833-807-2264**.  
If you have questions, please call Bright Start® at **1-833-212-2264**.

Date:

Provider information	
Provider name:	Tax ID:
Address:	
Phone:	Fax:

Member information				
Member name:	Medicaid ID:			
Address:	Email:			
Date of birth:	Language preferred:	Phone:		
Tobacco use	Pre-pregnancy	First trimester	Second trimester	Third trimester
Average number of cigarettes smoked per day. If none, enter 0; one pack = 20 cigarettes				

Pregnancy information and history					
Date of first prenatal visit:			17P candidate: <input type="checkbox"/> Yes <input type="checkbox"/> No		
EDD:	Gest. age:	Gravida:	Para:	Pre-term:	Living:
Abortions: Spontaneous:		Induced:		<input type="checkbox"/> Three consecutive abortions	

Last pregnancy			
<input type="checkbox"/> N/A	<input type="checkbox"/> History of incompetent cervix	<input type="checkbox"/> Fetal death after 20 weeks	<input type="checkbox"/> History of sexually transmitted infection (STI)
<input type="checkbox"/> Birth weight < 2,500 grams	<input type="checkbox"/> Premature rupture of membranes	<input type="checkbox"/> Preeclampsia/eclampsia	<input type="checkbox"/> Postpartum depression
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Classical incision previous C-section	<input type="checkbox"/> Intrauterine growth restriction	<input type="checkbox"/> History of deep vein thrombosis and/or pulmonary embolism
<input type="checkbox"/> Preterm delivery (gest. age: )			
<input type="checkbox"/> Congenital anomaly:			
<input type="checkbox"/> Other (specify):			

Current pregnancy			
Multiple gestation: <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other:		<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> Eclampsia
<input type="checkbox"/> Premature labor	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rh sensitization	<input type="checkbox"/> Renal disease
<input type="checkbox"/> Placenta previa	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Abnormal ultrasound
<input type="checkbox"/> Premature rupture of membranes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Alcohol or drug problems
<input type="checkbox"/> STI	<input type="checkbox"/> Previous delivery within one year of estimated date of delivery (EDD)	<input type="checkbox"/> Late and/or inconsistent prenatal care	<input type="checkbox"/> Poor weight gain
<input type="checkbox"/> Intrauterine growth restriction	<input type="checkbox"/> Second or third trimester bleeding	<input type="checkbox"/> Periodontal disease	<input type="checkbox"/> Pregnancy-induced hypertension
<input type="checkbox"/> Asthma		<input type="checkbox"/> HIV	<input type="checkbox"/> No current risk
<input type="checkbox"/> Other (specify):			<input type="checkbox"/> Seizure disorder

Active mental health conditions			
<input type="checkbox"/> No mental health conditions	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Other (specify):			

Social, economic, and lifestyle issues		
<input type="checkbox"/> No identified social, economic, or lifestyle issues	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Intellectual impairment
<input type="checkbox"/> Homelessness	<input type="checkbox"/> Opioid therapy	<input type="checkbox"/> Substance use disorder (specify type):
<input type="checkbox"/> Mental, physical, or sexual abuse (current or history of):		

Please call Bright Start or fax an updated form if the member has any changes in condition during pregnancy. This updated information can assist Bright Start with member outreach.