AETNA BETTER HEALTH® OF FLORIDA

Obstetrical Notification

Instructions: Complete this form at the first prenatal visit and fax to **1-860-607-8726**

Today's Date:			Enrollment: ☐Medicaid ☐Florida Healthy Kids	
Aetna Better Health Member ID #:			Medicaid # (if applicable):	
Member Name:			Home Phone:	Work Phone:
Member Address:				
Member Primary Language:			Translation Needed: ☐Yes ☐No	
OB Provider Name:			Tax ID#:	
OB Address:				
OB Phone:			OB Fax:	
Form Completed By:			Phone:	Ext:
Member DOB:	Height:	Weight:	Allergies:	
Date of first prenatal visit:	Gestational age first visit:	Gravida:	Parity:	EDD:
TOP/Abortions:	Miscarriages/Ectopic:	Premature (<37 wks):	#Living:	#Cesarean:

***Current* Pregnancy Risk Status**	**Medical & OB History** Indicate history of any of the following
☐ Age (<16 or >35 only)	☐ Asthma, on medication
☐ Fetal Anomaly: _____	☐ Autoimmune Disease:_____
☐ Fibroid (symptomatic)	☐ Baby over 10 lbs.
☐ Gestational Diabetes	☐ Blood Disorder:_____
☐ Alcohol use in pregnancy	☐ Cardiac condition ☐Chronic Hypertension
☐ Illegal (street) drug use, this pregnancy	☐ Cone Biopsy of Cervix
☐ Incompetent Cervix:	☐ Crohn's Disease or GI disorder
Cerclage planned? ☐Yes ☐No	☐ Deep Vein Thrombosis
☐ IVF Pregnancy	☐ Diabetes ☐Type 1 ☐Type 2
☐ Hyperemesis-weight loss or ketones	☐ Gestational Diabetes (previous pregnancy)
☐ Morbid Obesity (250 lbs or 100 lbs over IBW)	☐ Hepatitis B or C
☐ Multiple Gestations: ☐Twins ☐Triplets ☐More:____	☐ Intrauterine Fetal Demise (>20 wks)
☐ Pregnancy Induced Hypertension	☐ Seizure Disorder
☐ Placenta Previa:	☐ PIH/Eclampsia/Toxemia/HELLP Syndrome
☐low lying ☐marginal ☐partial ☐complete	☐ Placenta Previa ☐Placenta abruption >20 weeks
☐ Psychiatric Disorder(s) on medication	☐ Polyhydramnios/Oligiohydramnios
☐ Blood Disorder(s):_____	☐ Preterm delivery (<37 weeks) at _____ weeks
☐ Sexually transmitted disease:_____	☐ Premature rupture of membranes ☐Renal Condition
☐ Uterine Anomaly	☐ Uterine anomaly/uterine surgery (exclude C-Sect)
☐ Other high risk OB conditions:_____	☐ Other significant medical/OB history:_____
☐ Issues with housing, access to food	***Tobacco Status (must check one):*** ☐Non-Smoker ☐Smoker ☐ Vaping
BELOW MUST BE COMPLETED	☐ Stopped smoking since pregnancy ☐Referral for tobacco cessation
☐ HbsAG Screening completed or declined and signed	**HEALTHY START**
☐ HIV/AIDS Screening completed or declined and signed	Member was screened for "Healthy Start" on:
☐ Domestic Violence Screening completed	Date: _____ Score:_____
☐ Referral to WIC ____Yes ____No	Risk Screening forwarded to County Health Department: ☐Yes ☐No
☐ Advance Directives on file ____Yes ____No	

PLEASE ATTACH OFFICE VISIT NOTES