DELAWARE PHYSICIANS CARE
AN AETNA MEDICAID PLAN℠

252 Chapman Road
Newark, DE 19702
Fax to: (866) 815-1941

PERINATAL CARE AND RISK ASSESSMENT FORM

MEMBER NAME _____
STREET ADDRESS: _____ ID#:_____ DOB: _____
CITY/STATE: _____ PHONE: _____ SS#: _____
EMERGENCY CONTACT: _____ PRIMARY LANGUAGE: _____
CONTACT PHONE #: _____ RACE: ☐ CAUCASIAN ☐ NATIVE AMER
☐ AFRICAN AMER ☐ ASIAN
PCP: _____ ☐ HISPANIC ☐ OTHER
OBSTERICIAN/MIDWIFE: _____ MARITAL STATUS: ☐ MARRIED ☐ SINGLE
☐ SEPARATED ☐ WIDOWED ☐ DIVORCED
OFFICE PHONE: _____
PLANNED:
VAGINAL _____ PRIMARY C/S _____
VBAC _____ REPEAT C/S _____
REASON FOR PLANNED C-SECTION:
PRIOR CLASSICAL C/S _____ ELECTIVE _____
MYOMECTOMY _____ METROPLASTY _____
OTHER MEDICAL/SURGICAL _____
ANTICIPATED SITE FOR DELIVERY: _____
DATE OF INITIAL PRENATAL VISIT: _____ GESTATIONAL AGE AT FIRST VISIT: _____
GRAVIDA: _____ PARA: _____ EDC: _____ LMP: _____

PRE-EXISTING MEDICAL CONDITIONS (Check all that apply)

☐ DIABETES
☐ DIET ☐ INSULIN RD ☐ FAMILY ☐ SELF
☐ RENAL DISEASE
☐ CYTOMEGALO VIRUS (CMV) / TOXOPLASMOSIS
☐ CARDIOVASCULAR DISEASE
☐ PULMONARY DISEASE/ASTHMA
☐ URINARY TRACT INFECTION
☐ HYPERTENSION
☐ FAMILY ☐ SELF
☐ SMOKING
☐ RH NEGATIVE
☐ SEIZURE DISORDERS
☐ SICKLE CELL BLOOD/DYSCRASIA
☐ VAGINAL INFECTION
☐ DVT, PHLEBITIS, VARICOSE VEINS
☐ AIDS/HIV
☐ HEPATITIS B
☐ OTHER _____
☐ CANCER
SITE _____
☐ STD
☐ DRUG/ALCOHOL DEPEND
☐ POSITIVE GENETIC SCREENING
☐ PSYCH DIAGNOSIS _____

OBSTERICAL COMPLICATIONS IN CURRENT OR PRIOR PREGNANCY
(Indicate in box for all that apply: "C" for current Pregnancy; "P" for Prior Pregnancy)

☐ PRETERM LABOR OR DELIVER – 35 WEEKS
☐ INCOMPETENT CERVIX
☐ RECURRENT SPONTANEOUS AB (3 OR MORE)
☐ POLY/OLIGOHYDRAMNIOS
☐ PREGNANCY INDUCED HYPERTENSION (PIH)
☐ IGUR/UTERINE ABNORMALITIES
☐ CANCER (GYN)
☐ ANOMALOUS FETUS
☐ GESTATIONAL DIABETES
☐ HYPEREMESIS GRAVIDORUM
☐ AGE < 18 OR >34
☐ HEMORRHAGE (POST-PARTUM)
☐ PLACENTA PREVIA/ABRUPTION
☐ EXPOSURE TO MEASLES, MUMPS, CHICKEN POX >36 WKS
☐ <1 YR BETWEEN PREGNANCIES
☐ ABNORMAL ULTRASOUND
☐ POST-TERM (42 WKS)
☐ C-SECTION
☐ HERPES (ACTIVE HX)
☐ +RPR
☐ MULTIFETAL PREGNANCY
☐ FETAL ARRYTH/BRADYCARD
☐ 4 OR MORE PREGNANCIES
☐ PREGNANCY > 18 WEEKS
☐ OTHER: _____

REMARKS:

SIGNATURE OF M.D. /R.N. COMPLETING FORM: _____ DATE: _____
PACT enrolled? Yes_____ No_____
Cell Phone number_____