



MVP Healthy Beginnings: PRENATAL REGISTRATION FORM

Date Completed: _____
Name: _____ **DOB:** _____ **Contract #:** _____
Current Address: _____
City: _____ **State:** _____ **Zip:** _____ **Pt. Phone:** _____
EDC: _____ **Diagnosis:** _____ Normal Preg. High Risk Preg.
G: _____ **P:** _____ **Registered For Prenatal Care** _____ **Weeks By LMP/Ultrasound** _____

Billing Prenatal Care Provider: _____ **Billing Group Number:** _____

MD Phone: _____ **Hospital (for delivery):** _____

Date of 1st PN Visit: _____

Race: African American Latino/Hispanic Asian/Pacific Islander Non-white other White

To help assess for individual needs and additional services, please complete the following. Check all applicable risk categories.

I	SOCIAL RISK FACTORS:		
	<input type="checkbox"/> No Phone	<input type="checkbox"/> Primary Language _____	<input type="checkbox"/> Unemployed/DSS > 1 year
	<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Unstable Living Arrangement	<input type="checkbox"/> No Family Support <input type="checkbox"/> WIC Referrals
	<input type="checkbox"/> Transportation: Problem with keeping Appointments	<input type="checkbox"/> Secondary Smoke in Residence	
	<input type="checkbox"/> History of Physical/Sexual Abuse: Is this a current problem? <input type="checkbox"/> Yes <input type="checkbox"/> No		
II	MATERNAL MEDICAL HISTORY:		
	<input type="checkbox"/> DVT/Pulm. Embolism	<input type="checkbox"/> Hx Pyelonephritis	<input type="checkbox"/> Primary Hypertension
	<input type="checkbox"/> Hx. DES Exposure	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Asthma/COPD
	<input type="checkbox"/> Current Cigarette Use	<input type="checkbox"/> Preventive Dental Visit w/in last 6 mos <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
	<input type="checkbox"/> Hx STD's	<input type="checkbox"/> Any Dental Problems _____	
III	PSYCHO-NEUROLOGICAL HISTORY:		
	<input type="checkbox"/> Clinical/Post Part. Depression	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Takes Medication For Mental Illness
	<input type="checkbox"/> Previous Counseling Eval or Treatment, For How Long? _____		<input type="checkbox"/> Desires Counseling Referral
	<input type="checkbox"/> Substance/Alcohol Abuse Hx.	<input type="checkbox"/> Current Use? List Substance _____	
	<input type="checkbox"/> Mentally/Physically Challenged: _____		
	<input type="checkbox"/> HIV Testing Occurred	<input type="checkbox"/> HIV Counseling Recommended	
IV	MATERNAL OBSTERICAL HISTORY:		
	<input type="checkbox"/> Current PTL <input type="checkbox"/> Hx of PTL	<input type="checkbox"/> Previous Uterine Surgery, Describe _____	
	<input type="checkbox"/> Prev. Gestational Diabetes	<input type="checkbox"/> Tocolytics used @ _____ weeks gestation	
		<input type="checkbox"/> Previous use of 17-OH Progesterone _____	
	<input type="checkbox"/> Preg. Induced Hypertension	<input type="checkbox"/> Abruptio Placenta	<input type="checkbox"/> Eating Disorder, List _____
	<input type="checkbox"/> Placenta Previa	<input type="checkbox"/> Pre-Eclampsia	<input type="checkbox"/> < 12 Months Between Births
V	PREVIOUS INFANT/FINDINGS		
	<input type="checkbox"/> Stillbirth >28 Weeks	<input type="checkbox"/> Birthweight <2500 Gms.	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Preterm birth < 30 Weeks	<input type="checkbox"/> Preterm Birth 30-36 Weeks	<input type="checkbox"/> Birthweight >4000 Gms.

Please list any other medical/psychological problems not included above or other issues which may place this patient at risk in pregnancy: _____

Provider Completing Form (please print): _____ **Title:** _____

M.D. (or Representative) Signature: _____ **Date:** _____

1. Do you want a home environment assessment to identify issues which may be impacting this pregnancy? Yes No

2. Current Community Agencies Involved: _____

3. Does member desire assistance in linking to community services? Yes No

IF CLINICAL FINDINGS OR SOCIAL FINDINGS CHANGE DURING THIS PREGNANCY, PLEASE BE SURE TO CONTACT MVP CASE MANAGEMENT by fax at 585-258-8603 or by phone at 585-258-8666.

I understand that this information will be kept confidential. It may be used by the case manager to collaborate with the member's prenatal care provider for changes in the plan of care. Release of information on reverse side-must be read and signed by member/patient

Consent For Release of Information

Member Name: _____
Last First Middle

Date of Birth: _____ Contract Number: _____

PLEASE COMPLETE ALL 3 SECTIONS

Section A

Check all that apply: **ONLY INFORMATION CHECKED BELOW IS APPROVED FOR RELEASE:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> All clinical records |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medical Assessment | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Lab/Test results | <input type="checkbox"/> Educational Testing | <input type="checkbox"/> Genetic Testing |
| <input type="checkbox"/> Treatment Plan/Recommendations | <input type="checkbox"/> Other: _____ | |

Purpose or need for disclosure: The information identified above will be disclosed for the purpose of providing and coordinating your prenatal care as well as any related health and social services you may require, as part of prenatal program, *Healthy Beginnings*.

Section B Please check at least one box in both categories:

- Permission is given to:
- MVP Health Care
 - Healthcare Providers from which I receive prenatal services and other agencies participating in the prenatal program, *Healthy Beginnings* including Peer Place Network Agencies* in Monroe County.
 - Other: _____

- To disclose information to:
- MVP Health Care
 - Healthcare Providers from which I receive prenatal services and other agencies participating in the prenatal program, *Healthy Beginnings* including Peer Place Network Agencies* in Monroe County.
 - Other: _____

* Peer Place Network Agencies include organizations such as the Nurse-Family Partnership, Perinatal Home Visiting Program, Baby Love, and other child and family health services programs. Network organizations are subject to change over time.

Section C: Please check all those that apply:

- I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose general medical information.
- I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose substance abuse (alcohol/drug) treatment information. I understand that any disclosure of the records of Federally assisted alcohol or drug abuse treatment programs is bound by Title 42 of the Code of Federal Regulations.
- I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose mental health information.

I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire one year from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply.

Time period, event or condition replacing period specified above: _____

Member signature Date

Print Name of Member

Signature of Personal Representative of member, if applicable:
 Parent Legal Guardian Other: _____

I hereby cancel my authorization to release the information outlined on this form

Member signature Date Witnessing signature Date

This consent is voluntary. MVP Health Care, nor any other provider or agency participating in the *Healthy Beginnings Program* may condition treatment or benefits on my willingness to sign this authorization.