

MATERNITY RISK SCREEN

The *risk screen is designed* to identify pregnant women at risk for preterm birth or poor pregnancy outcome. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ **Medicaid #** _____ **EDC** _____

A. MEDICAL

	Substance abuse	# days/week	# times/day
		<i>used</i>	<i>used</i>
1. _____ Hypertension, chronic or preg. induced	8. Alcohol	_____	_____
2. _____ Gestational diabetes/diabetes	9. Cocaine/crack	_____	_____
3. _____ Multiple gestation (twins, triplets)	10. Narcotics/heroin	_____	_____
4. _____ Previous preterm birth < 5 ½ lbs.	11. Marijuana/hashish	_____	_____
5. _____ Advanced maternal age, > 35 yrs	12. Sedatives/ tranquilizers	_____	_____
6. _____ Medical condition, the severity of which affects pregnancy, document below	13. Amphetamines/ diet pills	_____	_____
7. _____ Previous fetal death	14. Inhalants/glue	_____	_____
	15. Tobacco/cigarette	_____	_____
	16. Other, please specify	_____	_____

B. SOCIAL

- | | |
|--|--|
| 1. _____ Teenager 18 yrs or younger | *4. _____ Abuse/neglect during pregnancy |
| 2. _____ Non compliant with medical directions
or appointments | *5. _____ Shelter, homeless or migrant |
| 3. _____ Mental retardation or history of
emotional/mental problems | *6. _____ Lack of food |

C. NUTRITION

- | | |
|---|---|
| 1. _____ Teenager 18 years or younger | 3. _____ Poor diet or pica |
| 2. _____ Prepregnancy underweight/overweight
inadequate or excessive wt gain | 4. _____ Obstetrical/Medical condition requiring
diet modification, document condition below |

REFERRALS AND/OR SERVICE PLAN

- | | | |
|----------------------------|---|-------------------------------|
| 1. _____ Care Coordination | 4. _____ Nutritional Counseling | 7. _____ Substance Abuse TX |
| 2. _____ Smoking Cessation | 5. _____ Glucose Monitor w/nutrition counseling | |
| 3. _____ Homemaker | 6. _____ Parenting/Childbirth Classes | 8. _____ No Care Coordination |

PROVIDERS COMMENTS OR SUGGESTIONS

SIGNATURE/TITLE _____ **SCREENING DATE** _____

SIGNATURE PRINTED _____ **PROVIDER #** _____

****Refer to District Office MOMS staff for follow up***