HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Fax Completed Form: 702-804-3732

MATERNITY RISK SCREENING FORM

Member Information:

Member Name (first, middle initial, last):

Member ID #: Member's Date of Birth:

Estimated Date of Delivery (EDD): Trimester of Pregnancy: ☐1st☐2nd☐3rd Date of First Visit:

Last Menstrual Period:

Provider Information:

Provider Name (first, middle initial, last):

Provider ID Number:

Additional Comments from Provider:

Please check all that apply:

A. OBSTETRICAL/MEDICAL	
☐ Advanced maternal age > 35 yrs.	☐ Periodontal disease
☐ Anemia	☐ Previous fetal death
☐ Cardiac condition	☐ Previous preterm birth before 37 weeks
☐ Gestational diabetes/diabetes	☐ Asthma/Respiratory condition
☐ Hepatitis	☐ Sickle cell/Clotting disorders
☐ HIV+/AIDS	☐ STD (specify):
☐ Hypertension, chronic or pregnancy induced	☐ 17-P Candidate: ☐ Yes ☐ No
☐ Multiple gestation (twins, triplets)	☐ Other, please specify:

B. PSYCHOSOCIAL	
☐ Abuse/domestic violence during pregnancy	☐ Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc.
☐ Anxiety / Depression / Mental Health disorder	☐ Teenager 18 years or younger
☐ Homeless / Unstable housing	☐ Tobacco / Alcohol use
☐ Lack of food	☐ Transportation
☐ Last delivery within 1 year of EDD	☐ Other Social Concerns:
☐ Current Methadone Treatment	

REFERRALS AND/OR SERVICE PLAN	
☐ Care Coordination	☐ Parenting/Childbirth Classes
☐ Glucose Monitor w/nutrition counseling	☐ Perinatologist/Specialist
☐ Home Health	☐ Substance Abuse TX
☐ Mental Health	☐ Tobacco Cessation (Rx or Referral given)
☐ Nutritional Counseling	

PROVIDER SIGNATURE/STAMP_____ **DATE**_____

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-962-8074 (TTY: 711).