AUTHORIZATION/PREGNANCY RISK ASSESSMENT

Phone 602.778.1800 (Options 5, 6) Fax 602.778.1838

Date: _____

PROVIDER INFORMATION:

Physician Name:	Fax:
Street Address:	Phone #/Office Contact:
Group Name/TIN #:	FQHC? : Yes☐
City, State, ZIP:	Date of 1st visit in your office (required for auth):

MEMBER INFORMATION:

Member Name:	EDC (required for auth):		
Member ID:	High Risk: Why:		
Street Address:	LMP:	Weeks:	WIC:
City, State, Zip:	Weight Now:	Pre – Preg:	
Phone Number:	Date of Birth:	Age:	
Primary Language Spoken:	Other Insurance:		

PREGNANCY HISTORY (circle or fill in the blank with number)

How many pregnancies? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐___ Multiple Pregnancy: ☐ Twins ☐ Triplets ☐ Other

Number of living children? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐___ Induced abortions: _____

Premature Labor: _____ Premature Deliveries: _____ Miscarriages: _____

Vaginal deliveries: _____ C/Sections: _____ Why? _____

Smoke? ☐ Yes ☐ No How much? _____ Drink Alcohol? ☐ Yes ☐ No How Much? _____

Street Drugs: ☐ Yes ☐ No _____

All Current Medications: _____

Medication Allergies? ☐ Yes ☐ No _____

Any problems with pregnancy? _____

Any Problems with Previous Pregnancies? _____

Significant social history? _____

MEDICAL PROBLEMS

☐ Heart ☐ Lung ☐ Kidneys ☐ Diabetes ☐ Asthma ☐ High Blood Pressure

☐ Other

☐ Previous Surgeries:

Any previous HIV exposure or history? Has HIV status been confirmed with lab work?

Any History of STD's?

Received prenatal care prior to filling out this form?

If yes, from whom?

Hospital for delivery:

CARE 1ST HEALTH PLAN ARIZONA USE ONLY

Dates

Authorization #: _____ From: _____

Completed By: _____ To: _____

Submit the Pregnancy Risk Assessment Form within thirty (30) days from the initial visit. If not submitted timely, authorization may be considered for visits only. Please complete the form in its entirety. If you have questions, call our Maternal Child Health (MCH) Team at 602.778.1800 x 8336. The risk assessment form is used by Case Management for assessment of member needs and risks.