

# OHIO DEPARTMENT OF MEDICAID PRENATAL RISK ASSESSMENT FORM

Please Print or Type:

<b>Patient Name</b>	<b>Case/Recipient Number</b>	<b>Expected Date of Delivery (EDD):</b> month / day / year
<b>Patient Address</b>	<b>Physician Name</b>	
<b>Patient Telephone</b>	<b>Physician Telephone</b>	Please check Diagnostic Code for this assessment:  <input type="checkbox"/> V22 <input type="checkbox"/> V23
<b>Case Name if different from patient name</b>	<b>Enrollment in Managed Care Plan (HMO):</b> Please check <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please check all that apply:

Distribution: Original in provider file, Copy to CDJFS

## AT RISK OF PRETERM BIRTH

If at least one factor is checked, patient is at risk of preterm birth – V23.8

**OBSTETRICAL HISTORY**

- |  |  |
|--|--|
| <input type="checkbox"/> 1. ABORTION, 1 <sup>st</sup> or 2 <sup>nd</sup> trimester, spontaneous or therapeutic | <input type="checkbox"/> 5. INCOMPETENT CERVIX                 |
| <input type="checkbox"/> 2. CONE BIOPSY  | <input type="checkbox"/> 6. LOW BIRTH WEIGHT, less than 2500 g |
| <input type="checkbox"/> 3. DES EXPOSURE   | <input type="checkbox"/> 7. PRETERM DELIVERY/LABOR             |
| <input type="checkbox"/> 4. ECLAMPSIA OR SEVERE PRECLAMPSIA  |  |

**CURRENT PREGNANCY**

- |   |   |
|---|---|
| <input type="checkbox"/> 8. ABDOMINAL SURGERY                                 | <input type="checkbox"/> 25. MALIGNANCY OR LEUKEMIA                             |
| <input type="checkbox"/> 9. AGE, less than 19 or more than 35 years           | <input type="checkbox"/> 26. MISSED PRENATAL APPOINTMENTS                       |
| <input type="checkbox"/> 10. ANEMIA, less than 11 hgb or less than 33% hct    | <input type="checkbox"/> 27. MULTIPLE GESTATION                                 |
| <input type="checkbox"/> 11. ANEMIA, Sickle Cell or other hemoglobinopathy    | <input type="checkbox"/> 28. OLIGOHYDRAMNIOS                                    |
| <input type="checkbox"/> 12. ASTHMA, on medication                            | <input type="checkbox"/> 29. PLACENTA PREVIA, 3 <sup>rd</sup> trimester         |
| <input type="checkbox"/> 13. BLEEDING, if significant after 12 weeks          | <input type="checkbox"/> 30. PNEUMONIA  |
| <input type="checkbox"/> 14. CERVIX DILATED, more than 1.5 cm before 29 weeks | <input type="checkbox"/> 31. POLYHYDRAMNIOS                                     |
| <input type="checkbox"/> 15. CERVIX EFFACED, less than 1 cm before 29 weeks   | <input type="checkbox"/> 32. POOR NUTRITION                                     |
| <input type="checkbox"/> 16. CHRONIC BRONCHITIS                               | <input type="checkbox"/> 33. PRENATAL CARE NONCOMPLIANCE, most recent pregnancy |
| <input type="checkbox"/> 17. DIABETES, insulin dependent                      | <input type="checkbox"/> 34. PRETERM LABOR                                      |
| <input type="checkbox"/> 18. DOMESTIC VIOLENCE                                | <input type="checkbox"/> 35. PROM, confirmed                                    |
| <input type="checkbox"/> 19. DRUG OR ALCOHOL ABUSE                            | <input type="checkbox"/> 36. KIDNEY DISEASE, UTI (urinary tract infections)     |
| <input type="checkbox"/> 20. ECLAMPSIA OR PREECLAMPSIA                        | <input type="checkbox"/> 37. SMOKING  |
| <input type="checkbox"/> 21. HEART DISEASE                                    | <input type="checkbox"/> 38. TRAUMA   |
| <input type="checkbox"/> 22. HYPERTENSION, on medication                      | <input type="checkbox"/> 39. UNDERWEIGHT  |
| <input type="checkbox"/> 23. IRRITABLE UTERUS                                 | <input type="checkbox"/> 40. UTERINE ANOMALY OR FIBROIDS                        |
| <input type="checkbox"/> 24. LATE INITIAL VISIT, after 14 weeks of pregnancy  | <input type="checkbox"/> 41. WEIGHT LOSS  |
|   | <input type="checkbox"/> 42. OTHER _____  |

## AT RISK OF POOR PREGNANCY OUTCOME

If at least one factor is checked, patient is at risk of poor pregnancy outcome – V23.9

**OBSTETRICAL HISTORY**

- |  |   |
|--|---|
| <input type="checkbox"/> 43. CONGENITAL ANOMALY, major | <input type="checkbox"/> 44. INFANT DEATH: Stillborn, Neonatal, Post Neonatal |
|--|---|

**CURRENT PREGNANCY**

- |   |  |
|---|--|
| <input type="checkbox"/> 45. ANESTHESIA RELATED ALLERGIES                     | <input type="checkbox"/> 56. ILLITERACY OR LANGUAGE BARRIER                |
| <input type="checkbox"/> 46. DEEP VENOUS THROMBOSIS                           | <input type="checkbox"/> 57. ISOIMMUNIZATION associated with fetal disease |
| <input type="checkbox"/> 47. DIABETES, GESTATIONAL, diet controlled           | <input type="checkbox"/> 58. MENTAL RETARDATION                            |
| <input type="checkbox"/> 48. DRUG OR ALCOHOL ABUSE                            | <input type="checkbox"/> 59. OBESITY, more than 20% weight for height      |
| <input type="checkbox"/> 49. EPILEPSY or on anticonvulsant                    | <input type="checkbox"/> 60. PRIOR C-SECTION                               |
| <input type="checkbox"/> 50. FAMILIAL GENETIC DISORDER, confirmed             | <input type="checkbox"/> 61. PSYCHOSIS, within past 5 years                |
| <input type="checkbox"/> 51. GRAND MULTIPARA, more than 5 of 20 weeks or more | <input type="checkbox"/> 62. RECENT DELIVERY, less than 1 year             |
| <input type="checkbox"/> 52. GROUP B STREPTOCOCCAL DISEASE                    | <input type="checkbox"/> 63. RUBELLA EXPOSURE with rising titer            |
| <input type="checkbox"/> 53. HEIGHT, less than 5 feet                         | <input type="checkbox"/> 64. SEXUALLY TRANSMITTED DISEASE, any             |
| <input type="checkbox"/> 54. HEPATITIS OR CHRONIC LIVER DISEASE               | <input type="checkbox"/> 65. THYROID DISEASE, confirmed                    |
| <input type="checkbox"/> 55. HIV / ARC / AIDS                                 | <input type="checkbox"/> 66. TUBERCULOSIS, active                          |
|   | <input type="checkbox"/> 67. OTHER _____                                   |

**Physician's Signature**

**Date**