Maternity Screening Form:

EI's Name:

County: **Region Name/Number:**

Program:

Care Coordinators Name: **Title:**

Screening Date:

Medicaid eligibility: _____
LMP _____ EDC _____
Multifetal Pregnancy o *Single* o *Twins* o *Triplets* o *Quads* o *Other* o *unknown*
Marital status *(*single, divorced, widowed, separated) _____
Father of Baby name: Last First
Date of last delivery _____
Date of Pregnancy test _____
Delivering Health Care Professional (DHCP) Last name First name
DHCP address
DHCP telephone number
DHCP NPI Number
Have you seen a DHCP? Yes____ If yes, date: _____ No _____
Next DHCP appointment date _____
Weeks gestation at first prenatal visit _____
EDC: confirmed date _____
Referral Source: o *Patient* o *Provider* o *DHR* o *Social Services* o *Other*
Living arrangement: (house, apartment, with family, homeless, etc.)
Other health related issues

Previous Pregnancy History:

Number of previous pregnancies (Gravida)
Number of deliveries after 20 weeks (Para)
Spontaneous Abortion (SAB) *(please explain)*
Elective Abortion.. (EAB) *(please explain)*
Stillborn
Previous Births before 38 wks

Pregnancy Number 1:

Gestational age at delivery (or end of pregnancy)
Birth Weight
❒Live birth ❒SAB ❒EAB ❒Stillborn ❒Death of Infant < one year of age (+2)
DOB
❒Vaginal Delivery ❒Caesarean section (C/S) ❒ Vaginal birth after Caesarean (VBAC)
Child's Name Vaginal birth after Caesarean
Gender o *Male* o *Female*

Pregnancy Number 2:

Gestational age at delivery (or end of pregnancy)
Birth Weight
❒Live birth ❒SAB ❒EAB ❒Stillborn ❒Death of Infant < one year of age (+2)
DOB
❒Vaginal Delivery ❒C/S ❒VBAC
Child's Name
Gender o *Male* o *Female*

Pregnancy Number 3:

Gestational age at delivery (or end of pregnancy)
Birth Weight
❒Live birth ❒SAB ❒EAB ❒Stillborn ❒Death of Infant < one year of age (+2)
DOB
❒Vaginal Delivery ❒C/S ❒VBAC
Child's Name
Gender o *Male* o *Female*

Pregnancy Number 4:

Gestational age at delivery (or end of pregnancy)
Birth Weight
❒Live birth ❒SAB ❒EAB ❒Stillborn ❒Death of Infant < one year of age (+2)
DOB
❒Vaginal Delivery ❒C/S ❒VBAC
Child's Name
Gender o *Male* o *Female*

Pregnancy Number 5:

Gestational age at delivery (or end of pregnancy)
Birth Weight
❒Live birth ❒SAB ❒EAB ❒Stillborn ❒Death of Infant < one year of age (+2)
DOB
❒Vaginal Delivery ❒C/S ❒VBAC
Child's Name
Gender o *Male* o *Female*

Additional Pregnancies