Pregnancy Risk Screening and Notification
Fax to: 1-888-670-7260

Children's Mercy PEDIATRIC CARE NETWORK

MO PCN Prior Authorization Phone: 1-877-347-9367
KS PCN Prior Authorization Phone: 1-833-802-6427
www.cmics.org/pcn

To be completed by health care provider:

Name: First _____ Middle _____ Last _____

Member ID: _____ DOB: _____

Address: Street _____ Apt_____ City_____ State _____ Zip _____

Telephone: (____)_____ Alt. Telephone: (____)_____ County _____

Current Marital Status: Single Married Widowed Divorced Separated

Race: Bla White Am. Indian/Alaskan Hawaiian Pacific Islander Asian Other _____

Hispanic Origin: Yes No

English as a Second Language: Yes No Language Spoken _____

Interpreter Needed: Yes No Deaf/Hard of Hearing: Yes No

Gravida _____ Para _____ Aborta _____ Anticipated Delivery: Vaginal C-Section VBAC

LMP (mm/dd/yyyy): _____ EDC (mm/dd/yyyy): _____ 1st Prenatal Visit (mm/dd/yyyy): _____

Anticipated Delivering Hospital: _____ Anticipated Delivering City: _____

Check all risk factors below that apply. Circle if current/history or client/partner
(any risk checked qualifies client for prenatal case management)

- ☐ Mother's age ≤ 17 or ≥35 at time of conception
- ☐ Pre-pregnant weight < 100 lbs
- ☐ Pre-pregnant weight >200 lbs
- ☐ Diabetes ☐Gestational history/current ☐Type 1 ☐Type 2
- ☐ Vaginosis - **history/current** Syphilis - **history/current**
  Gonorrhea - **history/current** Chlamydia - **history/current**
- ☐ HIV
- ☐ Hepatitis B - **history/current**
- ☐ Hepatitis C - **history/current**
- ☐ Hypertension, Hx of 140/90 or > **history/current**
- ☐ Pregnancy Induced Hypertension **history/current**
- ☐ Incompetent cervix or cerclage **history/current**
- ☐ Interconceptual Spacing < 1 year
- ☐ Multiple gestation - **history/current**
- ☐ Late entry into care (after 4th month or 18 weeks gestation)
- ☐ Elevated blood lead level 15-19µg/dL or greater
- ☐ Gravida ≥ 7
- ☐ Other medical or social concerns:_____
  _____

- ☐ Preterm Labor - **history/current**
- ☐ Previous C-section
- ☐ Previous Fetal Death/Stillborn (20 wks or >)
- ☐ Previous Infant Death
- ☐ Prior Low Birthweight infant (<2500 gms)
- ☐ Smoking - **history/current** **client/partner**
- ☐ Domestic Violence - **history/current**
- ☐ Alcohol use - **history/current** **client/partner**
- ☐ Drug use - **history/current** **client/partner**
- ☐ Mental Illness - **history/current**
- ☐ Mother's education is < 8 years
- ☐ Homeless
- ☐ Living alone or single parent living alone
- ☐ Considering relinquishment of infant
- ☐ Unfavorable environmental conditions
- ☐ Neglect of children in the home
- ☐ Partner with history of violence

Did the provider counsel on smoking? Yes No
Did the provider counsel on alcohol use? Yes No
Did the provider counsel on substance use? Yes No

Was client directed to smoking cessation resource? Yes No
Was client directed to alcohol/substance abuse resource? Yes No
Was client directed to domestic violence resource? Yes No
Was client directed to prenatal case management resource? Yes No

Month Prenatal Case Management Began N/A 1 2 3 4 5 6 7 8 9

Enrolled in WIC at time of risk screening? Yes No
Verbal Screen or blood test for lead level performed? Yes No

Was client directed to WIC? Yes No
Was client directed to lead screening resource? Yes No

Insurance Prior Authorization Number: _____
(CMPCN will provide as appropriate)

Provider Name: _____ Performing Provider #: _____

Provider Phone: _____ Provider Fax: _____

Name of person completing form: _____ Title: _____ Date: _____