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: Black ☐ 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 ☐	Was client directed to smoking cessation resource?	Yes ☐ No ☐
Did the provider counsel on alcohol use?	Yes ☐ No ☐	Was client directed to alcohol/substance abuse resource?	Yes ☐ No ☐
Did the provider counsel on substance use?	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 ☐	Was client directed to WIC?	Yes ☐ No ☐
Verbal Screen or blood test for lead level performed?	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: _____