coordinated care

Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call Coordinated Care of Washington, Inc. 1-877-644-4613 (TTY:711). This form is also available online at www.coordinatedcarehealth.com.

***Required Field**

***Are You Pregnant?** ☐ Yes ☐ No * If you are pregnant, please continue to answer all the questions.

Return the form in the envelope provided. When your answers are received, a gift will be mailed to you!
We may call you if we find that you are at risk for problems with your pregnancy.

***Medicaid ID #:** Today's Date MMDDYYYY:

Your First Name:

Your Last Name:

***Your Birth Date MMDDYYYY:**

Mailing Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Would you like to receive text messages about pregnancy and newborn care? ☐ Yes ☐ No

If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe.
Please note, texting is not secure and may be seen by others.

Email Address:

***Your OB Provider's Name:**

***Your Due Date MMDDYYYY:**

Primary insurance (for mom or baby) other than Medicaid? ☐ Yes ☐ No

Race/Ethnicity (select all that apply): ☐ White ☐ Black/African American ☐ Hispanic/Latina
☐ American Indian/Native American ☐ Asian ☐ Hawaiian/Pacific Islander
☐ Other If other ethnicity, please specify:

Preferred Language (if other than English):

Planning to breastfeed? ☐ Yes ☐ No If no, what is the reason?

Pediatrician chosen? ☐ Yes ☐ No Pediatrician Name:

Number of Full Term Deliveries: Number of Miscarriages:

Number of Preterm Deliveries: Number of Stillbirths:

Height (Feet, Inches): Pre-Pregnancy Weight:

***Do you have any of the following?** ☐ Yes ☐ No If yes, mark all that apply.

Your Medical History

Previous preterm delivery (<37 weeks or a delivery more than three weeks early)? ☐ Yes ☐ No

Recent delivery within past 12 months? ☐ Yes ☐ No Was delivery within past 6 months? ☐ Yes ☐ No

Previous C-Section? ☐ Yes ☐ No Diabetes (Prior to Pregnancy)? ☐ Yes ☐ No

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***Medicaid ID #:**

Name: Last, First:

Sickle Cell? Yes No

Asthma? Yes No If yes, are asthma symptoms worse during pregnancy? Yes No

High blood pressure (prior to pregnancy)? Yes No Previous neonatal death or stillbirth? Yes No

HIV Positive? Yes No HIV Negative? Yes No Testing refused? Yes No AIDS? Yes No

Thyroid Problems? Yes No If yes, is this a new thyroid problem? Yes No

Seizure Disorder? Yes No Seizure within the last 6 months? Yes No

Previous alcohol or drug abuse? Yes No

Current Pregnancy History

Preterm labor this pregnancy? Yes No Current gestational diabetes? Yes No

Current twins? Yes No Current triplets? Yes No

Currently having severe morning sickness? Yes No

Current mental health concerns? Yes No List:

Current STD? Yes No List:

Current tobacco use? Yes No Amount:

If yes, are you interested in quitting? Yes No

Current alcohol use? Yes No Amount:

Current street drug use? Yes No

Taking any prescription drugs (other than prenatal vitamins)? Yes No List:

Any hospital stays this pregnancy? Yes No

If yes, please list hospitalizations during this pregnancy.

Social Issues

Do you have enough food? Yes No Are you enrolled in WIC? Yes No

Do you have problems getting to your doctor visits? Yes No Do you have reliable phone access? Yes No

Are you homeless or living in a shelter? Yes No

Are you currently experiencing domestic violence or feel unsafe in your home? Yes No

Please list any other social needs you may have:

Please list anything else you would like to tell us about your health:

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