CalOptima Health Pregnancy Notification Report (PNR)

FAX this form within **five days** of the **first prenatal visit** to CalOptima Health at **714-246-8677**

MEMBER INFORMATION

Name:	CIN:	DOB:
Address:	City:	Zip Code:
Phone Number(s):	Member's Language:	

FIRST PRENATAL APPOINTMENT

Pregnancy Notification Report Status ☐ Initial ☐ Updated PNR	Date of first prenatal appt: _____/_____/_____	LMP: ____/____/_____ EDC: ____/____/_____	Gravida (G): Para (P):

MEMBER RISK FACTORS: Mark all conditions that apply. Provide comments as needed.

☐	Age < 15 years old Are minor's parents aware of the pregnancy? ☐ Yes ☐ No		☐	Age ≥ 35 years old
☐	Current diabetes *Attach any relevant lab testing	Mark one: ☐ Type 1 ☐ Type 2 ☐ Gestational diabetes	☐	Fetal Risk Factors: ☐ Fetal growth restrictions ☐ Inherited disease ☐ Chromosome Identifiers ☐ Birth defects
☐	Heart disease (congenital or acquired)		☐	History of preterm labor/delivery (<37 weeks)
☐	History of high-risk pregnancy		☐	☐ Hypertension/chronic high blood pressure ☐ Preeclampsia
☐	Incompetent cervix			
☐	Hyperemesis		☐	Weight: ☐ Low ☐ High Pre-pregnancy wt:_____ Current wt. _____ Height: ____ft. ___in. Pre-pregnancy BMI:_____
☐	Infectious disease (current): _____			
☐	Mental health disorder: _____			
☐	Late to care/insufficient care			
☐	**There is identified substance use**: Defined as current use or <1 month prior to pregnancy.		☐	There is a history or current Child Protective Services (CPS) involvement?
☐	**Identified substance:** Please indicate below ☐ Alcohol ☐ Illicit drugs ☐ Tobacco ☐ Other:___ Is there a Plan of Safe Care in place? ☐ Yes ☐ No		☐	The member has additional needs: ☐ Social support ☐ Access to medical care ☐ Housing ☐ Food WIC referral made on:_____

Other conditions and SDOH risk factors and/or comments:

Pregnancy risk has been identified as: ☐ Low risk ☐ Moderate risk ☐ High risk

PROVIDER INFORMATION

Provider Name:	**Phone:**	**Office Contact Name:**
Provider Fax:	**Did member receive a doula recommendation?** ☐ Yes ☐ No ☐ Member did not request	
Stamp	COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)	
	☐ **CPSP** will be provided through OB office	☐ **CPSP declined** in OB office
		☐ **Member** requests **NO** contact