AmeriHealth Caritas Louisiana

Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome.

Please complete and fax to AmeriHealth Caritas Louisiana at 1-888-877-5925.

Member information (*required field)		
Member ID number*:	Date of birth (mm/dd/yyyy):	
Last name:	First name:	
Mailing address:		
City:	State:	ZIP:
Home phone:	Cell phone:	
Email:		
Due date* (mm/dd/yyy):	Preferred language (if other than English):	
Date of first prenatal visit (mm/dd/yyyy):		Pre-pregnancy weight:
Race/ethnicity (fill in all that apply): ☐ White ☐ Black/African American ☐ Hispanic/Latina ☐ American Indian/Native American ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other (please specify):		
Number of full-term deliveries:	Number of stillbirths:	
Number of pre-term deliveries:	Number of miscarriages/abortions:	

Pregnancy risk assessment

Are any of the following risk factors present? ☐ Yes ☐ No

History (fill in all that apply)	
Previous pre-term (<37 weeks) delivery?	☐
If yes, was the delivery spontaneous?	☐
Is the member a candidate for progesterone injections?	☐
Recent delivery (within past 12 months)?	☐
Previous c-section?	☐
Diabetes (prior to pregnancy)	☐
Sickle cell disease:	☐
Asthma?	☐
High blood pressure (prior to pregnancy)	☐
HIV-positive?	☐
Seizure disorder?	☐
Seizure within the last six months?	☐
Previous alcohol or drug use?	☐

Current pregnancy (fill in all that apply)	
Pre-term labor this pregnancy?	☐
Shortened cervix <23 weeks this pregnancy? Length?	☐
Cervical cerclage placement?	☐
☐ Twins ☐Triplets ☐ Discordant?	☐
Current severe hyperemesis?	☐
Current mental health concerns? List:	☐
Current sexually transmitted diseases? List:	☐
Current tobacco use? Amount:	☐
Current alcohol use? Amount:	☐
Current street drug use? List:	☐

Provider information (*required field)

Date:		
OB provider name*:		
TIN/ID number*:	Phone number:	
Mailing address:		
City:	State:	ZIP:

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