Massachusetts Health Quality Partners Obstetrical Risk Assessment Tool

Name ____________________ (Last / First / Middle) Health Plan & Subscriber ID#____________

Address ____________________ (street / Apt.# / City / State / zip)

Phone: Home____________ Work:____________ Date of Birth:____________

Obstetrical Clinician's Name:____________ OB Provider ID#____________

Obstetrical Provider's Phone#____________ Fax:____________ EDC: ___/___/___

Planned Hospital for Delivery:____________ 1st Prenatal Visit Date: ___/___/___

Race: White ❑ Black ❑ Asian/Pacific Islander ❑ American Indian ❑ Other ❑ Ethnicity: Hispanic ❑ Non Hispanic ❑

Language spoken at home____________ Needs translation help Y ❑ N ❑ Support System Y ❑ N ❑

Behavioral Risks

Smoking Status

- Smokes regularly now, about the same as prior to pregnancy. Y ❑ N ❑
- Smokes regularly now but less than prior to the pregnancy. Y ❑ N ❑
- Smokes every once and a while. Y ❑ N ❑
- Quit smoking < 3 mo. prior to pregnancy Y ❑ N ❑
- Quit smoking since becoming pregnant. Y ❑ N ❑
- Wasn't smoking when became pregnant and doesn't smoke now. Y ❑ N ❑

Substance Abuse

Is the patient currently using alcohol? ____________ Y ❑ N ❑

Is the patient currently using street drugs?____________ Y ❑ N ❑

In the month prior to pregnancy:

How many drinks did the patient consume in one week? ____________

On how many occasions did the patient have more than 3 drinks? ____________

On how many occasions did the patient have any drugs? ____________

Occupational Demands Sedentary ❑ Active ❑ Hours spent standing______

Psychosocial Assessment completed Y ❑ N ❑

Psychosocial risk factors identified: (please circle) 1. frequent moves 2. care access 3. hungry 4. education 5. safe 6. violence 7. stress 8. pregnancy planning

Obstetrical High Risk/ Pre-Term Labor Assessment

Gravida________ Full Term________ Pre-term________ Abs________ Living________ Height:______ Weight:_____

Previous C/S? Y ❑ N ❑ VBAC discussed ❑ VBAC planned ❑ VBAC refused ❑ VBAC medically inappropriate ❑

Risk Factors: Past OB/GYN History Including Past Pregnancies **Initial Screen date ___/___/___**

Pre-term labor with previous pregnancy (less than 37 weeks) .... Y ❑ N ❑

Pre-term delivery with previous pregnancy (less than 37 weeks) .... Y ❑ N ❑

Diagnosis associated with pre-term delivery (narrative)____________

Incompetent cervix Y ❑ N ❑ Cerclage with previous pregnancy Y ❑ N ❑

DES Exposure .... Y ❑ N ❑

Two or more 2nd trimester abortions .... Y ❑ N ❑

Delivery within the past 12 months .... Y ❑ N ❑

Prior cone biopsy Y ❑ N ❑ Known uterine anomalies Y ❑ N ❑

Uterine fibroids Y ❑ N ❑ Myomectomy Y ❑ N ❑

Risk Factors: Current Pregnancy **26-28 weeks screening date ___/___/___**

ART this pregnancy Y ❑ N ❑ Gonadotropin Y ❑ N ❑ Clomophine Y ❑ N ❑

Multiple gestations Y ❑ N ❑ Fetal reduction Y ❑ N ❑

Presence of Bacterial Vaginosis this pregnancy Y ❑ N ❑ Treatment for BV Y ❑ N ❑

Bleeding after 12 weeks this pregnancy .... Y ❑ N ❑

Pre-term labor this pregnancy Y ❑ N❑ Cervical changes Y ❑ N ❑ Cerclage Y ❑ N ❑

Placenta previa beyond 26 weeks, this pregnancy .... Y ❑ N ❑

Polyhydramnios this pregnancy .... Y ❑ N ❑

Pregnancy Induced Hypertension this pregnancy .... Y ❑ N ❑

Gestational diabetes this pregnancy .... Y ❑ N ❑

Other Risk Factors current or past pregnancy (narrative)____________

I hereby authorize the Provider indicated herein to release the information on on this from to the named Health Plan

____________ Signature of Member Date ____________ Signature of Provider Date

Please fax this form to the appropriate office based on patient's health insurance (see information printed on back) Updated 3/02 © MHQP March 2002

Health Plan	Fax Number
Blue Cross Blue Shield of Massachusetts	(617) 246-3227
Harvard Pilgrim Health Care	(617) 509-1159 Attn: BIB program
Health New England, Inc.	(413) 734-3356
Neighborhood Health Plan	(617) 772-5512
Network Health	(617) 806-8103
Tufts Health Plan	(617) 972-9417