☐ Please fax to 585-697-1734 Monroe Plan, 2700 Elmwood Avenue, Rochester, NY 14618 Phone: 585-244-5550

Monroe Plan's Healthy Beginnings
PRENATAL REGISTRATION FORM

Date Completed: _____
Name: _____ DOB: _____ Contract #: _____
Current Address: _____
City: _____ State: _____ Zip: _____ Pt. Phone: _____
EDC: _____ Diagnosis: _____ ☐ Normal Preg. ☐ High Risk Preg.
G: _____ P: _____ Registered For Prenatal Care _____ Weeks By LMP/Ultrasound _____
Primary Prenatal Care Provider: _____ Group Number:_____
MD Phone: _____ Hospital (for delivery): _____
Date of 1st PN Visit: _____
Race: ☐ African American ☐ Latino/Hispanic ☐ Asian/Pacific Islander ☐ Non-white other ☐ White

To help assess for individual needs and additional services, please complete the following for this prenatal patient. Check all applicable risk categories.

I	**SOCIAL RISK FACTORS:**
	☐ No Phone ☐ Primary Language _____ ☐ Unemployed/DSS > 1 year ☐ Lives Alone ☐ Unstable Living Arrangement ☐ No Family Support ☐ Transportation: Problem with keeping Appointments ☐ Secondary Smoke in Residence ☐ History of Physical/Sexual Abuse: Is this a current problem? ☐Yes ☐No
II	**MATERNAL MEDICAL HISTORY:**
	☐ DVT/Pulm. Ebolism ☐ Hx Pyelonephritis ☐ Primary Hypertension ☐ Hx. DES Exposure ☐ Diabetes Mellitus ☐ Asthma/COPD ☐ Current Cigarette Use ☐ Dental Care Within the last year ☐Yes No ☐ ☐ Hx STD's ☐ Any Dental Problems _____
III	**PSYCHO-NEUROLOGICAL HISTORY:**
	☐ Clinical/Post Part. Depression ☐ Suicide Attempt ☐ Takes Medication For Mental Illness ☐ Previous Counseling Eval or Treatment, For How Long? _____ ☐ Desires Counseling Referral ☐ Substance/Alcohol Abuse Hx. ☐ Current Use? List Substance _____ ☐ Mentally/Physically Challenged:_____
IV	**MATERNAL OBSTERICAL HISTORY:**
	☐ Current PTL ☐ Hx of PTL ☐ Previous Uterine Surgery, Describe _____ ☐ Prev. Gestational Diabetes ☐ Tocolytics used @ _____ weeks gestation ☐ Preg. Induced Hypertension ☐ Abruptio Placenta ☐ Eating Disorder, List _____ ☐ Placenta Previa ☐ Pre-Eclampsia ☐ < 12 Months Between Births
V	**PREVIOUS INFANT/FINDINGS**
	☐ Stillbirth >28 Weeks ☐ Birthweight <2500 Gms. ☐ Other _____ ☐ Preterm birth < 30 Weeks ☐ Preterm Birth 30-36 Weeks ☐ Birthweight >4000 Gms.

Please list any other medical/psychological problems not included above or other issues which may place this patient at risk in pregnancy: _____
_____
_____

Provider Completing Form (please print): _____ Title: _____
M.D. Signature: _____ Date: _____

1. Do you want a home environment assessment to identify issues which may be impacting this pregnancy? ☐Yes ☐No

2. Current Community Agencies Involved: _____

3. Does member desire assistance from Monroe Plan in linking to community services? ☐Yes ☐No

IF CLINICAL FINDINGS OR SOCIAL FINDINGS CHANGE DURING THIS PREGNANCY, PLEASE BE SURE TO CONTACT CASE MANAGEMENT.

I understand that this information will be kept confidential. It may be used by the case manager to collaborate with the member's prenatal care provider for changes in the plan of care. Release of information on reverse side-must be read and signed by member/patient. **(Over)**