BlueCross BlueShield Nebraska

Obstetrical Needs Assessment Form

Please fax or mail this form to: Blue Cross and Blue Shield of Nebraska
1919 Aksarben Drive • PO Box 3248 Omaha, NE 68180-0001
Fax: 402.548.4695 **Phone:** 402.982.8539

Member Information

Member ID Number: ____________________

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):	Telephone Number:
Address:	City, State, Zip Code:			
Email:		Date of initial prenatal visit/Diagnosis date:		Completion date of pregnancy form:

Pregnancy Information and History

LMP	Gestational age at first visit	EDC	Gravida	Para	Pre-term	Living	Abortions
____	____	____	____	____	____	____	Spontaneous: ____ Induced: ____

Risk Factors (past or current)

- ☐ No Risk Factors
- ☐ Diabetes/GDM/LGA baby
- ☐ DVT/PT
- ☐ Eclampsia/Pre-eclampsia
- ☐ Fetal congenital anomaly or disorder
- ☐ Fetal death
  - ☐ Second trimester ☐ Third trimester
- ☐ Hypertension/GHTN
- ☐ Incompetent cervix
- ☐ IUGR/SGA baby
- ☐ Late and/or inconsistent prenatal care
- ☐ Low birth weight < 2500 grams
- ☐ Multiple gestation
- ☐ Placenta abnormalities
  - ☐ Abruption ☐ Previa
- ☐ Premature ROM
- ☐ Pre-term (specify gestational age)
  - ☐ Delivery: ____________
  - ☐ Labor: ____________
- ☐ Renal Disease
- ☐ Sickle cell disease/trait
- ☐ Abnormal ultrasound: ____________
- ☐ Uterine abnormality: ____________
- ☐ Other: ____________

Active Medical Conditions

- ☐ None
- ☐ Advanced maternal age
- ☐ Asthma
- ☐ Auto-immune disease(s)

  ____
- ☐ BMI (low or high): ____________
- ☐ Hepatitus
- ☐ HIV
- ☐ Seizure disorder: ____________

Thyroid disease - treated?
- ☐ Yes ☐ No
- ☐ Other (specify): ____________

Social, Economic and Lifestyle Factors

- ☐ No Risk Factors
- ☐ Behavioral health condition

  ____
- ☐ Domestic violence
- ☐ Housing issues
- ☐ Identified social, economic and lifestyle

  ____
- ☐ Intellectual impairment
- ☐ Lack of support system
- ☐ Literacy issues
- ☐ Mental/physical/sexual abuse (current or history of): ____________
- ☐ Postpartum depression
- ☐ Smoking/tobacco use; individualized intervention offered?
  - ☐ Yes ☐ No
- ☐ Substance abuse:
  - ☐ Alcohol: ____________
  - ☐ Drug abuse: ____________
- ☐ Teen pregnancy: ____________
- ☐ Other (specify): ____________

STI History

	Screen Date	Negative	Positive
☐ HIV:	________	☐	☐
☐ Syphilis:	________	☐	☐
☐ Gonorrhea:	________	☐	☐
☐ Chlamydia:	________	☐	☐

Current Medications

☐ No Medications

Please list: ____________

Provider Information

Provider Name:	Tax ID Number:	Phone Number:	Fax Number:	Delivery Hospital:
Address:	City, State, Zip Code:			

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Signature of provider (MD/DO/APRN/PA): ______________________ Date: ____________

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