



TOTAL OB PRIOR AUTHORIZATION (TOB PA)

NOTICE OF PREGNANCY (NOP) FORM



PA Authorization Number: _____

Patient Name: Last _____ First _____ DOB: _____

Health Plan: _____ Phone: _____ Alternate Phone: _____

AHCCCS #: _____ EDD: _____ LMP: _____

Gravida _____ Para _____ Aborta _____ Anticipated Delivery: Vaginal _____ C-Section _____ VBAC _____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

Race: White _____ Black _____ Hispanic _____ Am. Indian _____ Hawaiian Pacific Islander _____ Asian _____ Other _____

English as a second language: Yes _____ No _____ Language(s) spoken _____

Interpreter needed: Yes _____ No _____ Deaf/Hard of Hearing: Yes _____ No _____

Check all risk factors below that apply/ Circle if current/history-client/partner

(Any risk checked qualifies client for prenatal case management)

- | | |
|---|--|
| <input type="checkbox"/> 1. Pre-pregnant weight <100 lb or >200 lbs | <input type="checkbox"/> 15. History of Preterm Delivery / Preterm Labor |
| <input type="checkbox"/> 2. Hyperemesis | <input type="checkbox"/> 16. Teen mother or mother age 35 years or greater |
| <input type="checkbox"/> 3. Diabetes ___ Gestational ___ Type 1 ___ Type 2 | <input type="checkbox"/> 17. Placenta Abnormalities / Problems |
| <input type="checkbox"/> 4. STD - Vaginosis, Syphilis, Herpes, Gonorrhea, Chlamydia | <input type="checkbox"/> 18. Previous Fetal Death/Stillborn (> 20 wks) |
| <input type="checkbox"/> 5. HIV positive | <input type="checkbox"/> 19. Previous Infant Death- less than 1 year old |
| <input type="checkbox"/> 6. Hepatitis A, B, C history / current | <input type="checkbox"/> 20. Prior Low Birth weight infant (<2500 grams) or NICU |
| <input type="checkbox"/> 7. Chronic Medical Condition: _____ | <input type="checkbox"/> 21. Smoking- history/current |
| <input type="checkbox"/> 8. Fetal Anomalies history/ current | <input type="checkbox"/> 22. Domestic Violence/ Family/Partner - history/current |
| <input type="checkbox"/> 9. Pregnancy Induced Hypertension history / current | <input type="checkbox"/> 23. Alcohol use- client/partner / history / current |
| <input type="checkbox"/> 10. Incompetent cervix or cerclage history/ current | <input type="checkbox"/> 24. Substance Abuse-client/partner/ history / current |
| <input type="checkbox"/> 11. Cervical changes (dilation/effacement), prior to 35 wk | <input type="checkbox"/> 25. Mental Illness, PPD - history/current |
| <input type="checkbox"/> 12. Interconceptual Spacing < 1 year | <input type="checkbox"/> 26. Social Needs, lack of support from family/friends |
| <input type="checkbox"/> 13. Multiple gestation- history/current | <input type="checkbox"/> 27. Homeless / Living at Shelter |
| <input type="checkbox"/> 14. Intrauterine growth restriction | <input type="checkbox"/> 28. Late Prenatal Care (after 4 th mo or 18 wks gestation) |
| | <input type="checkbox"/> 29. Other _____ |

Did the provider counsel on smoking? Yes ___ No ___	Was client directed to smoking cessation resource? Yes ___ No ___
Did the provider counsel on alcohol use? Yes ___ No ___	Was client directed to alcohol/substance abuse resource? Yes ___ No ___
Did the provider counsel on substance abuse? Yes ___ No ___	Was client directed to domestic violence resource? Yes ___ No ___

Enrolled in WIC @ time of risk screening? Yes ___ No ___ Was Client directed to WIC? Yes ___ No ___

Date: _____ Diagnosis/ICD-9 Code _____ / _____

Requesting Provider: _____

Provider Office PA Contact: _____ Provider Phone: _____ Fax: _____

OBGYN/PCP OB Location: _____ Anticipated Delivering Hospital: _____

Priority Standard Expedited *Please note that we may request that inappropriate Expedited requests be downgraded

Date of first prenatal visit: _____