Prenatal Notification Form

The earliest possible completion of this form allows Molina Healthcare to coordinate care for your patient. Please fax this completed form to Molina at (888) 656-7541.

Member information

Member name:			Member ID #:	
Member DOB:	Primary language:		Member phone:	
Address:				
City:	State:		ZIP:	
Date of positive pregnancy test:	Date of first prenatal visit:		Health screening completion date:	
LMP:	EDC:	Gravida:	Para:	Living:

Current pregnancy risks and/or medical conditions (Please check any that apply)

- ☐ Diabetes
- ☐ Preeclampsia and/or chronic hypertension
- ☐ Pre-term labor
- ☐ Renal disease
- ☐ Heart disease
- ☐ Sickle cell disease
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Placenta previa
- ☐ Twins
- ☐ Seizure disorder
- ☐ Fetal anomaly
- ☐ Late and/or inconsistent prenatal care
- ☐ Homelessness
- ☐ Domestic violence
- ☐ Nutritional risk:_____
- ☐ Psychiatric disorder:_____
- ☐ Substance abuse:_____
- ☐ Tobacco use: _____
- ☐ Alcohol use:_____
- ☐ STD:_____
- ☐ Other risk and/or diagnosis:_____

Medical conditions from previous pregnancies (Please check any conditions that apply)

- ☐ Postpartum depression
- ☐ Hypertension
- ☐ Diabetes
- ☐ Pre-term delivery
- ☐ Previous c-section
- ☐ Incompetent cervix
- ☐ Low birth weight < 2,500 grams
- ☐ Placenta previa
- ☐ Preeclampsia
- ☐ Gestational diabetes
- ☐ Spontaneous abortion or fetal demise
- ☐ PROM or PPROM

Provider information

Provider name:		Provider ID #:	
Phone number:		Fax number:	
Address:	City:	State:	ZIP: