Prenatal and Postpartum Care

Please fax completed forms to **833-667-1532** or send to our secure email **MIHEDIS@mhplan.com** and save a copy in the patient's medical record.

Patient Name: _____ DOB: _____ ID#: _____

Date Vitals Collected: ___/___/____ Blood Pressure: ____/_____ Weight: _____lbs. BMI: _____

EDC or EDD: _____ DD: _____ LMP: _____

Prenatal Visit Date	**Type of Service(s) Performed**	
1.	☐ Pregnancy diagnosis ☐ Fetal heart tones ☐ Cervical exam ☐ Fundal height ☐ Ultrasound	☐ OB Panel ☐ Prenatal risk assessment and counseling/education ☐ Complete obstetrical history
2.	☐ Pregnancy diagnosis ☐ Fetal heart tones ☐ Cervical exam ☐ Fundal height ☐ Ultrasound	☐ OB Panel ☐ Prenatal risk assessment and counseling/education ☐ Complete obstetrical history
Postpartum Visit Date (occurring between seven and 84 days after delivery)	**Type of Service(s) Performed**	
1.	☐ Pelvic exam ☐ Evaluation of weight, blood pressure, breasts, and abdomen ☐ Perineal/cesarean incision/wound check ☐ Screening for depression, anxiety, tobacco use, substance use, or preexisting mental health disorders	☐ Glucose screening (for women with gestational diabetes) ☐ Review of infant care or breastfeeding ☐ Discussion regarding resumption of intercourse, birth spacing, or family planning ☐ Discussion regarding sleep/fatigue

	☐ Discussion regarding resumption of physical activity and attainment of healthy weight

Provider Name and Credentials (Print): _____

Provider Signature: _____ Date: _____/_____/_____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and signoff.