





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

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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.

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