



# Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call Meridian at 888-437-0606 (TTY: 711). This form is also available online at [www.mimeridian.com](http://www.mimeridian.com)

**\*Required Field**

**\*Are You Pregnant?**  Yes  No \* If you are pregnant, please continue to answer all the questions.

Return the form in the envelope provided.  
We may call you if we find that you are at risk for problems with your pregnancy.

**\*Medicaid ID #:**  Today's Date MMDDYYYY:

Your First Name:

Your Last Name:

**\*Your Birth Date MMDDYYYY:**

Mailing Address:

City:  State:  Zip Code:

Home Phone:  Cell Phone:

Would you like to receive text messages about pregnancy and newborn care?  Yes  No

If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe. Please note, texting is not secure and may be seen by others.

Email Address:

**\*Your OB Provider's Name:**

**\*Your Due Date MMDDYYYY:**

Primary insurance (for mom or baby) other than Medicaid?  Yes  No

Race/Ethnicity (select all that apply):  White  Black/African American  Hispanic/Latina  
 American Indian/Native American  Asian  Hawaiian/Pacific Islander  
 Other If other ethnicity, please specify:

Preferred Language (if other than English):

Planning to breastfeed?  Yes  No If no, what is the reason?

Pediatrician chosen?  Yes  No Pediatrician Name:

Number of Full Term Deliveries:  Number of Miscarriages:

Number of Preterm Deliveries:  Number of Stillbirths:

Height (Feet, Inches):  Pre-Pregnancy Weight:

**\*Do you have any of the following?**  Yes  No If yes, mark all that apply.

**Your Medical History**

Previous preterm delivery (<37 weeks or a delivery more than three weeks early)?  Yes  No

Recent delivery within past 12 months?  Yes  No Was delivery within past 6 months?  Yes  No

Previous C-Section?  Yes  No Diabetes (Prior to Pregnancy)?  Yes  No



\*Medicaid ID #:

Name: Last, First:

Sickle Cell?  Yes  No

Asthma?  Yes  No If yes, are asthma symptoms worse during pregnancy?  Yes  No

High blood pressure (prior to pregnancy)?  Yes  No Previous neonatal death or stillbirth?  Yes  No

HIV Positive?  Yes  No HIV Negative?  Yes  No Testing refused?  Yes  No AIDS?  Yes  No

Thyroid Problems?  Yes  No If yes, is this a new thyroid problem?  Yes  No

Seizure Disorder?  Yes  No Seizure within the last 6 months?  Yes  No

Previous alcohol or drug abuse?  Yes  No

**Current Pregnancy History**

Preterm labor this pregnancy?  Yes  No Current gestational diabetes?  Yes  No

Current twins?  Yes  No Current triplets?  Yes  No

Currently having severe morning sickness?  Yes  No

Current mental health concerns?  Yes  No List:

Current STD?  Yes  No List:

Current tobacco use?  Yes  No Amount:

If yes, are you interested in quitting?  Yes  No

Current alcohol use?  Yes  No Amount:

Current street drug use?  Yes  No

Taking any prescription drugs (other than prenatal vitamins)?  Yes  No List:

Any hospital stays this pregnancy?  Yes  No

If yes, please list hospitalizations during this pregnancy.

**Social Issues**

Do you have enough food?  Yes  No Are you enrolled in WIC?  Yes  No

Do you have problems getting to your doctor visits?  Yes  No Do you have reliable phone access?  Yes  No

Are you homeless or living in a shelter?  Yes  No

Are you currently experiencing domestic violence or feel unsafe in your home?  Yes  No

Please list any other social needs you may have:

Please list anything else you would like to tell us about your health:

If your answers indicate you are at an increased risk for complications during this pregnancy, would you consent to participate in our Start Smart Case Management program to help you and your baby?

Yes  No

