AdvancedHealth
Bridging the Future of Healthcare

Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Instructions to Complete High Risk Pregnancy Checklist

- Once Advanced Health has been sent a Pregnancy Notification form by a provider for a pregnant Member, Advanced Health will send the OB provider a High Risk Pregnancy Checklist to fill out and send back. This form helps identify pregnant Members that may be at high risk for complications or other issue.
- The OB provider is responsible for completing the second section of the form once the Member has been evaluated.
- Fax completed form to Advanced Health's Case Management Department at (541) 269-7147.
- If you have questions regarding this form or other related issues, please contact Advanced Health's Case Management Department at (541) 269-7400, extension 127.

To complete the form, please follow these instructions:

Date of First Visit: Enter the date of the Member's first visit to the OB provider

Due Date: Enter the Member's expected date of delivery

Risk Factors:

Low Risk: Mark this item if there are no risk factors/no concerns found

High Risk: Mark this item and any of the following risk factors if any of the risk factors apply to the Member:

- <17 or >40 years of age
- RH Factor
- First pregnancy or >5 pregnancies • Smoking
- Late prenatal Care (20 weeks)
- STD/HIV
- Alcohol and/or drug abuse
- Domestic abuse
- Chronic diseases (high blood pressure, diabetes, asthma, etc.)

Please specify concerns: Identify any specific concerns that you have for the member that are in addition to the above risks mentioned

Other comments or concerns: Use this area for additional information that if felt pertinent to the Member's pregnancy and/or condition.

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High Risk Pregnancy Checklist

Fax completed form to: (541) 269-7147 • Attention: Case Management

The following is to be completed by the Medical Management Department:

Patient Name: ________________________________ Date of Birth: _____/_____/_____

OB Provider: __________________________________ Provider Phone Number: ______________________

The following is to be completed by the Member's OB provider:

Date of First Visit: _____/_____/_____ Due Date: _____/______/______

Risk Factors:

_____ Low Risk (No Concerns)

_____ High Risk (Please indicate concerns/issues below)

_____ <17 or >40 years

_____ First Pregnancy or >5 Pregnancies

_____ RH Factor

_____ Late Prenatal Care (20 weeks)

_____ Smoking

_____ Alcohol and/or Drug Abuse

_____ STD/HIV

_____ Domestic Abuse

_____ Chronic Diseases (high blood pressure, diabetes, asthma)

Concerns/Comments:

Please specify concerns:

Other comments or concerns: