OB REGISTRATION FORM

Complete and return this form for all obstetrical patients assigned to Optima Health. Information is used by care management teams to educate members and coordinate care.
Please fax this form back to Optima Health at 1-804-799-5117

Patient Information				
Member's Name:		Age:	Date of Birth:	
Current Address:			Optima Health ID#	
Patient's Phone Numbers: (Home) Alternate Phone Number:	(Cell)		Today's Date :	

Provider Information				
Name of Facility:	Name of Obstetrician:	NPI Number:	Phone Number:	Fax Number:

Patient History				
Current Weight:	Pre-Pregnancy Weight	Height:	Last Menstrual Period:	Sonogram Performed:
Date Prenatal Care Initiated:		Gravida: Live Births:	Para: Ectopic:	EDC:

Risk Assessment

- ☐ Planned C-section
  - Indication:_____
- Smoker
- Substance Abuse
  - If yes, list:_____
- HIV/AIDS
- STD
  - IF yes, list:_____
- IUGR
- Incompetent Cervix
- Other:_____
- Do you consider this a High-risk Pregnancy?
  - If yes, explain:_____

Additional Comments:

_____
_____
_____
_____
_____

Previous Adverse Pregnancy Outcomes

- ☐ Premature Births
- ☐ Stillbirths
- ☐ Fetal Death
- ☐ Fetal Abnormalities
- ☐ Fetal Complications
- ☐ Abortion
- ☐ Other:

_____

Current Pregnancy Complications

- Maternal Bleeding
- Preeclampsia
- Diabetes
- Hypertension
- Nutritional Deficit
- Other:_____

Optima Health

Contact Us: P.O. Box 5307 Richmond, VA 23220
Fax to Medical Management: 1-800-827-7192
For Medical Management questions, call toll-free: 1-888-251-3063
All other questions, call toll-free: 1-800-881-2166 (TTY: 711)