

Obstetrical Needs Assessment (ONAF)

AmeriHealth Mercy Health Plan® /Gateway Health Plan®
 Unison Health Plan® /UPMC for You/UPMC Health Plan

FAX Information

Date initially faxed: _____ 28-32 week fax date: _____
 Post Partum Fax Date: _____

Member name (first, middle initial, last)

Date of birth

/ /

Member ID# or MA Recipient#

Home phone #

-

Alternate phone #

-

Hospital for Delivery

Gestational age 1st visit

weeks

Date of 1st Prenatal Visit

/ /

EDC date

/ /

Gravida

Para

Live births

TAB

17-P Candidate?

Yes No

Date Last PAP

/ /

Date Last Chlamydia Screen

/ /

Depression Screen?

Yes No

Dental visit past 6 mos?

Yes No

In Healthy Beginnings?

Yes No

Provider#

Practice Name:

Practice Phone #

-

Practice FAX#

-

Past OB Complications	Current Risks	Trimester			Active Maternal Medical Disorders	Trimester		
		1st	2nd	3rd		1st	2nd	3rd
<input type="checkbox"/> Gestational Diabetes	2 nd /3 rd trimester bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia Hb<10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Incompetent cervix	Abnormal placenta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IUGR	Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac disease (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Preeclampsia/Eclampsia	Missed Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Premature ROM	Perinatal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clotting disorder (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Preterm delivery <32 wks	Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Preterm delivery 32-36 wks	Poor weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Preterm labor <32 wks	Preeclampsia/Eclampsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Previous C-Section	Premature ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal disease (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Recurrent 2 nd trimester loss	Preterm dilation of cervix (>1.5cm) or Preterm Labor, <32 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal Visit Dates	Previous delivery within 1 year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	Social, Economic, Lifestyle Risks	Trimester			STD (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>		1st	2nd	3rd	Thyroid disease (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	Currently Using Tobacco Cessation Services Offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other medical issues:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Postpartum Visit (Should be between 21-56 days after delivery)			
<input type="text"/> / <input type="text"/> / <input type="text"/>	Eating disorder (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/> / <input type="text"/> / <input type="text"/>	History of chronic depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of post partum visit: <input type="text"/> / <input type="text"/> / <input type="text"/>			
<input type="text"/> / <input type="text"/> / <input type="text"/>	Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Method Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both <input type="checkbox"/>			
<input type="text"/> / <input type="text"/> / <input type="text"/>	Mental health disorder (specify) Currently on Rx Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Postpartum depression present <input type="checkbox"/>			
<input type="text"/> / <input type="text"/> / <input type="text"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Postpartum Contraception Discussed <input type="checkbox"/>			
<input type="text"/> / <input type="text"/> / <input type="text"/>	English not primary language Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quit Tobacco During Pregnancy Remains Tobacco Free <input type="checkbox"/>			
<input type="text"/> / <input type="text"/> / <input type="text"/>	Substance abuse: ETOH Street or Rx Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Comments:			
<input type="text"/> / <input type="text"/> / <input type="text"/>	Teen pregnancy Head of Household Aware	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/> / <input type="text"/> / <input type="text"/>	Other social issues (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/> / <input type="text"/> / <input type="text"/>					Community referrals made:			

Obstetrical Needs Assessment Form – Instructions for Completion

This form serves as the initial notification of a member’s pregnancy to her Health Plan. Prompt submission from your office allows us to enroll the member into our Maternity Management Programs as early as possible.

- **Please fill in the demographics section in its entirety for the first submission.**
- **Please complete the clinical section in its entirety for each submission by checking the trimester in which the risk or medical condition was noted.**
 - **Checked boxes indicate that the condition *was* identified by the provider’s office in that trimester.**
 - **Unchecked boxes indicate the risk *was not* identified.**
- **Please fill in the dates of all visits including the post partum visit.**
- **The ONAF form does not need to be filled out by a physician.**
- **The ONAF form can also be used to notify us regarding additional prenatal visits and newly identified risk factors. You do not need to complete the top part of the form each time. Simply add the new office visit(s) or risk factor(s) to the original form and fax it again.**
- **Please FAX the ONAF form to the member’s health plan ASAP after initial office visit in order to enable enrollment into our Pregnancy Case / Care Management Programs.**

The clinical information requested on the bottom of the form allows each Plan to risk-stratify our members to make appropriate referrals into our case management / care management programs. Updates to the form have been made based on feedback from many network OB Providers. The ***Current Risks*** and ***Active Maternal Medical Disorders*** sections have been expanded to better identify specific risks that could impact a pregnancy. A ***Community Referrals*** section was added at the request of Providers who want to let us know what they have already done for the member. This will enable our Maternity Case Managers to better reinforce your treatment plans when they contact the member by telephone.

FAX Numbers and Phone Numbers for Questions Regarding the ONAF Form:

AmeriHealth Mercy Health Plan	Gateway Health Plan®	Unison Health Plan®	UPMC <i>for You</i> / UPMC Health Plan
FAX: (717) 651-3591	FAX: (412) 255-5639 or 1-888-225-2360	FAX: (412) 457-1354 or 1-800-611-4411	FAX: (412) 454-8558
1-877-693-8271 Ext. 83485	MOM Matters SM Program 1-800-642-3550 Option 2	Miracles Pregnancy Program 1-800-414-6580	1-866-778-6073 Option 5
Electronic Form Entry? Call: 1-877-692-8271 Ext. 83570			