Select Health of South Carolina | Healthy Connections

Pregnancy Risk Assessment Information

Please fax this form to Select Health of South Carolina at **1.866.533.5493.**
If you have questions, please call Bright Start at 1.888.559.1010.

BRIGHTSTART

Provider Information

Provider name _____ Tax ID # _____

Address _____

Phone _____ Fax _____

Member Information

Member Name _____ Medicaid ID # _____

Address _____ Email _____

Date of birth _____ Language preferred _____ Phone _____

Tobacco use	Pre-Pregnancy	1st Trimester	2nd Trimester	3rd Trimester
Average number of cigarettes smoked per day. If none enter 0; 1 pack = 20 cigarettes				

Pregnancy Information & History

Date of first prenatal visit _____ 17P Candidate ☐ Yes ☐ No

EDC _____ Gest. Age _____ Gravida _____ Para _____ Pre-term _____ Living _____

Abortions: Spontaneous: _____ Induced: _____ ☐ Three consecutive abortions

Last Pregnancy

☐ Low birth weight < 2500 grams ☐ History of incompetent cervix ☐ Fetal death greater than 20 weeks ☐ STD history
☐ Gestational diabetes ☐ Premature ROM ☐ Pre-eclampsia/Eclampsia ☐ Postpartum depression
☐ Pre-term delivery (gest. age:_____) ☐ Classical incision previous C-section ☐ IUGR ☐ Hx of DVT/PE
☐ Congenital anomaly: _____
☐ Other (specify) _____

Current Pregnancy

☐ Multiple gestation: ☐ Twins ☐ Triplets ☐ Other: _____ ☐ Pre-eclampsia ☐ Eclampsia
☐ Premature labor ☐ Diabetes ☐ RH sensitization ☐ Renal disease
☐ Placenta previa ☐ Heart disease ☐ Sickle cell disease ☐ Abnormal ultrasound
☐ Premature rupture of membranes ☐ Hypertension ☐ Incompetent cervix ☐ Alcohol or drug problems
☐ STD (sexually transmitted disease) ☐ Previous delivery within 1 year of EDC ☐ Late and/or inconsistent prenatal care ☐ Poor weight gain
☐ IUGR ☐ 2nd/3rd trimester bleeding ☐ Periodontal disease ☐ PIH
☐ Seizure disorder ☐ Asthma ☐ HIV ☐ No current risk
☐ Other (specify) _____

Active Mental Health Conditions

☐ No mental health conditions ☐ Schizophrenia ☐ Bipolar ☐ Depression
☐ Other (specify) _____

Social, Economic and Lifestyle Issues

☐ No identified social, economic or lifestyle issues ☐ Eating disorder ☐ Intellectual impairment
☐ Homelessness ☐ Opiod therapy ☐ Substance abuse (specify type) _____
☐ Mental/physical/sexual abuse (current or hx. of) _____

Please call Bright Start or fax an updated form if the member has any changes in condition during pregnancy. This updated information can assist Bright Start with member outreach.

Maternity Authorization # _____
Covering dates of service _____to_____