



STORK PROGRAM ENROLLMENT FORM

Maternal-Child Health Risk Assessment

For questions about this form call: (855) 712-5090

Fax completed form to: (855) 720-5822

Date of Request: _____

Please ATTACH A COPY OF THE PRENATAL RECORD

MEMBER INFORMATION

Name: _____ Medicaid ID#: _____

Phone: _____ DOB: _____ Age: _____

PROVIDER INFORMATION

Name: _____ NPI: _____

Phone: _____ Fax: _____

Contact Person: _____ Extension: _____

Obstetrical ultrasounds to be billed under provider's NPI? YES NO

CLINICAL INFORMATION

LMP: _____ (not known) EDD: _____ (From LMP U/S)

Date of entry into prenatal care: _____ Date of first Visit in Provider's office: _____

***Note: If all information below is found on the attached prenatal record, it is not necessary to continue.**

Pre-Pregnancy Weight: _____ (not known) Current Weight: _____ Height: _____

History	Number (indicate if none)	Number (indicate if none)
Total # Pregnancies:	_____	# Living Children _____
# Deliveries after 37 0/7 weeks:	_____	# Miscarriages/Terminations: _____
# Deliveries 32 0/7 – 36 6/7 weeks:	_____	# Cesarean deliveries: _____
# Deliveries before 32 weeks:	_____	# VBAC deliveries: _____

Condition	(Check all that apply)	Current	Prior
TWINS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER MULTIPLE _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GESTATIONAL DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TYPE 1 or 2 DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PIH / PRE-ECLAMPSIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ECLAMPSIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHRONIC HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FETAL ANOMALIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENETIC DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BEHAVIORAL HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMESTIC VIOLENCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER OBSTETRICAL COND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER MEDICAL CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Condition	(Check all that apply)	Current	Prior
PRETERM BIRTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INCOMPETENT CERVIX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PLACENTA PREVIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PLACENTAL ABRUPTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POST PARTUM HEMORRHAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RENAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEPATIC DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUBSTANCE ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOBACCO USE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If checked, please explain