HIGHMARK
Phone: (716) 887-8734
FAX: (716) 887-7913
Medicaid Phone: (866) 231-0847
Medicaid FAX: (844) 812-2276

FIDELIS CARE
Phone: (800) 247-1441
FAX: (866) 815-7223

Independent Health
Phone: (716) 635-3523
FAX: (716) 631-3966

YourCare
Phone: (888) 638-7149
FAX: (800) 553-1160

WNY COLLABORATIVE
PRENATAL CARE RISK SCREENING and REFERRAL FORM

Member Last Name _____ Member First Name _____ Member ID #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____/_____/_____ Work/Cell phone: _____/_____/_____ DOB: ____/____/_____
MM DD YYYY

PNC Provider Information
Last Name: _____ First Name: _____

Address: _____ Provider ID # : _____

Tax ID #: _____ Phone: _____/_____/_____ Provider FAX: _____/_____/_____

Pregnancy information:

Initial Visit Date ____/____/_____ Gestational Age (weeks) _____ ☐ by LMP **OR** ☐ by Ultra sound
MM DD YYYY

Entry into PNC Gravida: ____ Para: ____ LMP ____/____/_____ EDC ____/____/_____
MM DD YYYY MM DD YYYY

Height_____ Weight_____ Pre-pregnancy BMI_____

Demographic information: Choose ALL that apply.

Race/ethnicity: ☐Caucasian ☐Black or African American ☐Asian ☐American Indian ☐Other
Primary Language: ☐English ☐Spanish ☐Other (specify) _____ Hispanic: ____Yes / ____No

Pregnancy Risk Factors: Check all risk factors that apply.

Prior	Current		Prior	Current		Prior	Current		Prior	Current	
☐	☐	Abdominal surgery	☐	☐	Pre-term labor	☐	☐	Fetal abnormality	☐	☐	<16 yr or > 35
☐	☐	C-Section	☐	☐	Preterm birth <37 wks	☐	☐	Multiple gestation	☐	☐	Depression
☐	☐	Cervical incompetence	☐	☐	LBW <2500gms 5½lbs	☐	☐	HTN/Preeclampsia	☐	☐	Alcohol use
☐	☐	Placenta Abruptio	☐	☐	Bt wt >4500gms/10lbs	☐	☐	Gestational Diabetes	☐	☐	Drug use
☐	☐	Placenta Previa	☐	☐	Stillborn/fetal death	☐	☐	STDs _____	☐	☐	Tobacco use

Medical Risk Factor: Check all risk factors that apply.

Yes	On Meds		Yes	On Meds		Yes	On Meds		Yes	On Meds	
☐	☐	Anemia	☐	☐	Diabetes Mellitus	☐	☐	Hypertension	☐	☐	Eating disorder
☐	☐	Asthma	☐	☐	DVT/Pulmonary Embolism	☐	☐	Kidney disease	☐	☐	Underweight
☐	☐	Auto-Immune disorder	☐	☐	Dental problem	☐	☐	Thyroid disorder	☐	☐	Overweight/Obese
☐	☐	Cardiac history	☐	☐	HIV/AIDS	☐	☐	Seizures	☐		Lead Exposure

Psycho-Social Risk Factors: Check all risk factors that apply.

				Yes	On Meds
☐ Unmarried/NO partner	☐ Unemployed (patient)	☐ Physical disability	☐ Unplanned pregnancy	☐	☐ Psychiatric diagnosis
☐ No family support	☐ Husband/partner unemployed	☐ Sexual abuse	☐ Children in foster care		
☐ Unstable housing	☐ Education<12 yrs	☐ Physical abuse	☐ Language barrier		
☐ Homeless	☐ Transportation problem	☐ Risk of self harm			
☐ No phone	☐ Mental disability	☐ Domestic violence			

Referrals Made: Check actions taken by the provider &/or those refused by the patient

Yes	Refused		Yes	Refused		Yes	Refused		Yes	Refused	
☐	☐	Community Case Manager	☐	☐	High Risk OB	☐	☐	Asthma Educator	☐	☐	WIC
☐	☐	Health Plan Case Manager	☐	☐	Substance Abuse	☐	☐	Diabetes Educator	☐	☐	Nutrition Counseling
☐	☐	Behavioral/ Mental Health	☐	☐	Tobacco Cessation Program	☐	☐	Home Visit Provider	☐	☐	Other
☐	☐	Domestic Violence	☐	☐	Dental Care	☐	☐	Supplemental Nutrition Assistance Program (Food Stamps)			

1) Does your patient want assistance with linkage or referral to services? ☐YES _____
2) Do you want assistance with linkage or referral of your patient to services? ☐YES _____

Name: _____ Date: _____ Practitioner Signature or office stamp:
Provider completing form

Current Pregnancy Risk: ☐ High ☐ At-Risk ☐ Low