PRENATAL REGISTRATION FORM
MVP Health Care Little Footprints℠
MVP Health Care, 220 Alexander Street, Rochester, NY 14607
Please fax to: 585-327-5759

PRENATAL REGISTRATION AND REFERRAL FORM

Date Completed: ______________________ **Date of 1st Prenatal Visit:** ______________________

Demographics

Patient Name:______________________ **DOB:**____________ **Insurance Name:** ______________

Current Address:______________________ **City, State:**______________________ **Zip:**

Phone:______________ **EDC:**__________ **Diagnosis:**______________ ☐ **Normal Pregnancy** ☐ **High Risk Pregnancy**

G:________ **P:**________ **Registered for Prenatal Care:**________ **Weeks by LMP/Ultrasound**________

Race: ☐ **African American** ☐ **Latino/Hispanic** ☐ **Asian/Pacific Islander** ☐ **Non-White/Other** ☐ **Other**

Billing Information

Primary Prenatal Care Provider:______________________ **Group NPI Number:** ______________________

MD Phone:______________________ **Hospital (for delivery):** ______________________

Date of First PN Visit:________ ☐ **First Trimester** ☐ **Second Trimester** ☐ **Third Trimester**

I	Social Risk Factors:
	Automatic Referral if 4 or more risk factors from this category or for active domestic violence
	☐ No Phone ☐ Primary Language ☐ Unemployed/DSS > 1 yr. ☐ Limited Social Support Network ☐ Lives Alone ☐ Unstable Living Arrangement ☐ No Family Support ☐ Transportation: Prob. With keeping Appointments ☐ Secondary Smoke in Residence ☐ History of Physical/Sexual Abuse: Is this a current problem?☐ Yes ☐ No
	For II, III, and IV, Automatic Referral if 5 or more risk factors identified from all three categories combined
II	Maternal Medical History:
	☐ DVT/Pulmonary Embolism ☐ Hx. Pyelonephritis ☐ Primary Hypertension ☐ Hx. DES Exposure ☐ Diabetes Mellitus ☐ Asthma/COPD ☐ Current Cigarette Use ☐ Dental Care Within last year ☐ yes ☐No ☐ Hx. STD's ☐ Any Dental Problems
III	Psycho-Neurological History:
	Automatic referral if desires counseling, current substance abuse or mentally/physically challenged
	☐ Clinical/Post Part. Depression ☐ Suicide Attempt ☐ Takes Medication for Mental Illness ☐ Previous Counseling Eval or Treatment, For How Long? ☐ Desires Counseling Referral ☐ Substance/Alcohol Abuse Hx ☐Current Use? List Substance ______________________ ☐ Mentally/Physically Challenged: ______________________
IV	Maternal Obstetrical History:
	Automatic Referral for any history or current PTL or <12 months between births
	☐ Current PTL ☐ Hx. PTL and/or Use of 17P ☐ Previous Uterine Surgery, Describe:____________ ☐ Hx. Gestational Diabetes ☐ Tocolytics used @________ weeks gestation ☐ Pregnancy Induced Hypertension ☐ Abruptio Placenta ☐ Eating Disorder, List______________ ☐ Placenta Previa ☐ Pre-Eclampsia ☐<12 Months Between Births
V	Previous Infant/Findings: ***Automatic Referral for any history of preterm birth or stillbirth***
	☐ Stillbirth >28 weeks ☐ Birth weight <2500 Gms. ☐ Other__________ ☐ Preterm birth <30 weeks ☐ Preterm Birth 30-36 Weeks ☐ Birth weight >4000 Gms.

Comments: ____

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Provider Completing Form (Please Print): ______________________ **Title:** ______________

MD Signature:______________________ **Date:** ______________________

Community Agencies Involved: ____

Consent for Release of Information:

Member Name: ______________________ ______________________ ______________________
Last **First** **Middle**

Date of Birth: ______________ **Contract Number:** ______________________

PLEASE COMPLETE ALL 3 SECTIONS

Section A:
Check all that apply: ONLY INFORMATION CHECKED BELOW IS APPROVED FOR RELEASE:

____Assessment/Evaluation	____Discharge Summary	____All Clinical Records
____Diagnosis	____Medical Assessment	____Progress Notes
____Lab/Test Results	____Educational Testing	____Genetic Testing

Purpose or need for disclosure: The information identified above will be disclosed for the purpose of providing and coordinating your prenatal care as well as any related health and social services you may require, as part of the 3fi Maternal Child Health initiative.

Section B: Please fill out for both Categories:

Permission is given to:

□ Healthcare providers from which I receive prenatal services and other agencies participating in the 3fi Maternal Child Health Initiative

□ Healthcare providers from which I receive prenatal services

□ Other

To disclose information to:

□ 3fi Maternal Child Health Network organizations (such as Baby Love, Healthy Moms, Nurse Family Partnership, Healthy start)

□ Other

Section C: Please check all that apply:

I, the undersigned, have read the above and authorize the practitioner, agency, or organization named section B to disclose general medical information

□ I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose substance abuse (alcohol/drug) treatment information. I understand that any disclosure of the records of federally assisted alcohol or drug abuse treatment programs is bound by Title 42 of the code of Federal Regulations.

□ I, the undersigned, have read the above and authorize the practitioner, agency or organization named in section B to disclose mental health information

I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. The consent shall expire three years from its signing, unless a different time period, event or condition is specified below, in which case such time such time period, Event or condition shall apply.

Member Signature ______________________________ Date: ______________________

Print Name of Member ______________________________

Signature of Personal Representative of Member, if applicable ______________________________

I hereby cancel my authorization to release the information outlined on this form:

Member Signature:______________________Date: __________ Witness Signature:______________________Date: __________

This consent is voluntary. No provider or agency participating in 3fi Maternal and Child initiative may condition treatment or benefits on my willingness to sign this authorization.

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