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)

Provider#

Practice Name:

____

Date of birth ___/___/_____ Member ID# or MA Recipient#

Practice Phone # ___ ___-____

Home phone # ___ ___-____ Alternate phone # ___ ___-____

Practice FAX# ___ ___-____

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

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

<u>FAX Numbers and Phone Numbers for Questions Regarding the ONAF Form</u>:

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