

FAX INFORMATION

Date initially faxed:	28 – 32 week fax date:	Postpartum fax date:
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PROVIDER INFORMATION

Provider name:	Provider number:
Practice phone number:	Practice fax number:

MEMBER INFORMATION

Member name (first, middle initial, last):	
Date of birth:	Member ID number or Medical Assistance recipient number:
Home phone number:	Alternate phone number:

Hospital for delivery:		
Gestational age first visit:	Date of first prenatal visit:	
Estimated date of confinement (EDC):	Date of last Pap test:	
Date last chlamydia screen:	Gravida:	Para:
Depression screen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Live births:	TAB:
17-P candidate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Women, Infants, and Children (WIC): <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental visit past six months? <input type="checkbox"/> Yes <input type="checkbox"/> No

PAST OB COMPLICATIONS

<input type="checkbox"/> No past OB complications	<input type="checkbox"/> Postpartum depression	<input type="checkbox"/> Preterm delivery 32 – 36 weeks
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Pre-eclampsia or eclampsia	<input type="checkbox"/> Preterm labor < 32 weeks
<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Premature rupture of membranes (ROM)	<input type="checkbox"/> Previous cesarean section
<input type="checkbox"/> Intrauterine growth restriction	<input type="checkbox"/> Preterm delivery < 32 weeks	<input type="checkbox"/> Recurrent second trimester loss

PRENATAL VISIT DATES

SOCIAL, ECONOMIC, AND LIFESTYLE RISKS	TRIMESTER		
	First	Second	Third
No social, economic, or lifestyle concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently using tobacco, with cessation services offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
English is not primary language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opioid therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use: alcohol, street, or Rx drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teen pregnancy, with head of household aware	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other social issues (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT RISKS	TRIMESTER		
	First	Second	Third
No current risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Second or third trimester bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal placenta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple gestations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missed prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perinatal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-eclampsia or eclampsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preterm dilation of cervix (> 1.5 cm) or preterm labor (< 32 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous delivery within one year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



ACTIVE MEDICAL OR MENTAL HEALTH CONDITIONS	TRIMESTER		
	First	Second	Third
No active medical or mental health conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia HbA1C < 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac disease (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting disorder (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, pregestational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal disease (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STD (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other medical issues:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DELIVERY INFORMATION
Delivery date:
At _____ weeks of gestation
Elective delivery: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean section
Vertex: <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth weight:
Viable: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neonatal intensive care unit (NICU) admission
Antenatal steroids: <input type="checkbox"/> Yes <input type="checkbox"/> No

Postpartum visit (Should be between 21 and 56 days after delivery)
Date of postpartum visit:
Feeding method: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both
Postpartum depression present: <input type="checkbox"/>
Postpartum contraception discussed: <input type="checkbox"/>
Quit tobacco during pregnancy: <input type="checkbox"/>
Remains tobacco free: <input type="checkbox"/>
Comments:
Community referrals made:

ONAF instructions for completion

This form serves as the initial notification of a member’s pregnancy to the AmeriHealth Caritas Delaware Bright Start program. Prompt submission from your office allows us to enroll the member into our Bright Start maternity program 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 or mental health 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 postpartum visit.
- The ONAF does not need to be filled out by a physician.
- The ONAF 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 **fax** the ONAF to the Bright Start program as soon as possible after the initial office visit to enable enrollment into our maternity care management program.

The requested clinical information helps AmeriHealth Caritas Delaware risk-stratify our members to make appropriate referrals into our care coordination program.

Phone: 1-833-669-7672
 Fax: 1-855-558-0488

www.amerihealthcaritasde.com

ACDE-1799946

