

**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNITY RISK SCREEN**

The risk screen is designed to identify high risk pregnant women as defined by the BabyCare program. Identify risks as listed below that apply to the client and make the appropriate referral(s). Please do not alter or add risks to the form. Additional information should be documented in the progress notes in the client's medical record.

Client Name _____ Medicaid # _____ EDC _____
 Client's Address _____ Phone # _____

A. MEDICAL RISKS

		SUBSTANCE ABUSE	# days/ week used	# times/ day used
1. _____	Hypertension, chronic or preg. induced	8. Alcohol	_____	_____
2. _____	Gestational diabetes/diabetes	9. Cocaine/crack	_____	_____
3. _____	Multiple gestation (twins, triplets)	10. Narcotics/heroin	_____	_____
4. _____	Previous preterm birth < 5½ lbs.	11. Marijuana/hashish	_____	_____
5. _____	Advanced maternal age, > 35 yr	12. Sedatives/tranquilizers	_____	_____
6. _____	Medical condition, the severity of which affects pregnancy, document below _____	13. Amphetamines/diet pills	_____	_____
7. _____	Previous fetal death	14. Inhalants/glue	_____	_____
		15. Tobacco/cigarettes	_____	_____
		16. Other drug, please specify _____	_____	_____

B. SOCIAL RISKS

- | | | | |
|----------|------------------------------------------------------------|----------|---------------------------------|
| 1. _____ | Teenager 18 years or younger | 4. _____ | Abuse, neglect during pregnancy |
| 2. _____ | Non-compliant with medical directions or appointments | 5. _____ | Shelter, homeless or migrant |
| 3. _____ | Mental retardation or history of emotional/mental problems | | |

C. NUTRITIONAL RISKS

- | | | | |
|----------|----------------------------------------------------------------------------------------|----------|------------------------------|
| 1. _____ | Prepregnancy underweight/overweight
Inadequate or excessive weight gain | 3. _____ | Poor diet or pica |
| 2. _____ | Obstetrical or medical condition requiring diet modification, document condition below | 4. _____ | Teenager 18 years or younger |

REFERRALS

1. ____ Care Coordination 2. ____ Nutritional Counseling 3. ____ Homemaker 4. ____ Parenting/Childbirth Class
 5. ____ Glucose Monitor with nutrition counseling 6. ____ Smoking Cessation 7. ____ Substance Abuse Treatment
 8. ____ No Care Coordination _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ National Provider Identifier: _____

Referral to High Risk Care Coordination