

**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT**

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (mo/day/year)	6. City/County of Residence		9. National Provider Identifier: _____
7. Race: 1. White 3. American Indian 5. Hispanic 2. Black 4. Asian 6. Other <input style="width:40px; height:20px;" type="text"/>			10. Provider Name & Address
8. Medicaid I.D. # Previous # if applicable			
11. Enter number of reason recipient is no longer requiring service			Date Closed: _____
1. Pregnancy ended 4. Lost to follow-up 7. Died 2. Dropped out of prenatal care 5. Eligibility cancelled 8. Moved 3. Transfer to other MICC agency 6. Problem resolved 9. Other (Specify):			<input style="width:80px; height:30px;" type="text"/>
12.. Pregnancy Outcome:			
Instructions: Enter pregnancy outcome number only if the answer to item 11 is "1 - PREGNANCY ENDED"			
1. Live birth 3. Therapeutic abortion 5. Fetal death 2. Spontaneous abortion 4. Elective abortion 6. Other:			<input style="width:80px; height:30px;" type="text"/>
13. Infant's Live Birth Data			
Instructions: Complete item 13 only if answer to item 12 is "1. LIVE BIRTH"			
	INFANT # 1		INFANT # 2
Birth Weight lbs. and ozs.	_____	_____	17. Is the infant receiving WIC services? Yes _____ No _____
Birth Date	_____	_____	18. Enter number weeks gestation when mother began prenatal Care _____
APGAR Score 1 min.	_____	_____	19. Total number of prenatal visits by mother during this pregnancy _____
5 min.	_____	_____	20. Did mother receive WIC during Pregnancy? Yes _____ No _____
14. Weeks gestation at time of birth _____			21. Did mother receive postpartum or family planning exam? Yes _____ No _____
15. Infant Risk Screen	Yes	No	
a. Has Physician completed risk screen?	_____	_____	
b. If yes, was the infant classified as "high risk"?	_____	_____	
c. If yes, has the infant been referred to care coordination	_____	_____	
d. If yes, was the infant born with morbidity?	_____	_____	
16. Infant receiving EPSDT services	_____	_____	
22. Client Needs			
Instructions: Indicate needs that were met through care coordinator assistance by entering "1" in the appropriate space(s). Indicate client needs that were not met at the completion of care coordination by entering "2" in the space(s).			
1. Child Care _____	5. Homemaker Serv. _____	9. Psychological _____	13. Smoking Cessation _____
2. Food Stamps _____	6. Home Health Serv. _____	10. Job Training _____	14. Glucose Monitoring _____
3. Housing _____	7. Employment _____	11. Transportation _____	15. Parenting/Childbirth _____
4. Nutrition Serv. _____	8. School Enrollment _____	12. Substance Abuse Treatment _____	
23. Substance abuse at time of delivery			
Instructions: Item 23 must be completed if substance abuse was indicated on the Care Coordination Record (DMAS-50)			
	# Days/ Week	# Times/ Day	# Days/ Week
Alcohol	_____	_____	Amphetamines/Diet Pills _____
Cocaine/Crack	_____	_____	Inhalants/Glue _____
Narcotics/Heroin	_____	_____	Tobacco/Cigarettes _____
Marijuana/Hashish	_____	_____	Other (Specify) _____
Sedatives/Tranquilizers	_____	_____	_____
Coordinator's Signature _____		Date _____	