

OBSTETRICAL NEEDS ASSESSMENT FORM (ONAF) – INSTRUCTIONS FOR COMPLETION

This form is intended for Medicaid Recipients participating in a HealthChoices Voluntary or Mandatory Managed Care Organization (MCO) or the Fee for Service delivery system.

This form serves as an MCO's or Fee for Service's initial notification of a member's pregnancy. Its prompt submission from your office allows us to enroll our members in the maternity program as early as possible.

General Instructions (the form does not need to be completed by a physician)

1. Please do not leave any question or section blank; fill out all information completely.
2. For maximum accuracy, please use a black pen and print CAPITAL LETTERS, avoiding contact with the edges of the boxes.
3. Please place an "X" or check mark through the box. (Do NOT shade in the squares completely).
4. Please write only in designated areas. Do not cross out entry and write above the box.
5. Please attach additional information if necessary.
6. Use the same form for all visits (so you will not need to complete the top part each time).
7. Please fill in the demographics section in its entirety.

Dates to complete the sections of the form are:

| Visit (Fax at these times) | Section to Complete |
|------------------------------------|--|
| First prenatal visit | Top portion; Past OB Complications; Current Risks; Active Medical/Mental Health Conditions and Social, Economic, Lifestyle |
| 28-32 week visit | Update all areas as needed, adding dates of prenatal visits thus far |
| Postpartum visit | Add postpartum information with date of visit and any additional visit dates as needed |
| New risk factors identified | Indicate on form where appropriate and fax form at any time during pregnancy |

Complete the first section as follows (OB/GYN Office Information):

| Entry | Instructions/Reason to Provide Information |
|---------------------------------|---|
| Practice name | Document the name of your practice or clinic |
| Phone # and Fax # | Document the phone number and fax number of practice or clinic |
| Provider Promise ID (13-digits) | Document provider's individual/group identification # including address locator |
| Initial Submission Date | Document date accordingly |
| 28-32 Week Submit Date | Document date accordingly |
| Postpartum (PP) Submit Date | Document date accordingly |
| Form Completed By | Document accordingly (This should be completed by healthcare professional) |

Complete the first section as follows (Member's Information):

| | |
|---------------------------------|---|
| First Name/Last Name | Document Member's full name |
| DOB | Document Member's date of birth |
| Age | Document Member's age at Expected Date of Confinement (EDC) |
| MAID# | Document Medical Assistance ID# |
| Member Health Plan | Document whether Member belongs to Aetna Better Health, AmeriHealth Caritas Pennsylvania, AmeriHealth Caritas Northeast, Fee for Service, Gateway Health SM , Geisinger Health Plan, Health Partners, Keystone First Health Plan, United Healthcare, or UPMC for You |
| Healthy Beginnings Plus Member | Indicate whether Member is enrolled as Healthy Beginnings Plus Member |
| Home Phone/Alternate Phone | Document Member's home phone and alternate phone (if applicable) |
| Language(s) | List primary language and any secondary language(s) (if applicable) |
| Hospital for Delivery | Document Member's choice of hospital for delivery |
| 1st Prenatal Visit | Date of first prenatal visit |
| EDC: | Expected date of confinement |
| By LMP of | Document if determined by last menstrual period and date of last menstrual period |
| By US, Date | Document if determined by ultrasound and date of ultrasound |
| GA at 1st Visit | Document gestational age at first prenatal visit |
| Gravida | Document Member's number of pregnancies |
| Full-term | Document number of pregnancies to full-term |
| Pre-term | Document number of pregnancies to pre-term |
| SAB | Document number of spontaneous abortions, if none indicate 0, DO NOT LEAVE BLANK |
| TAB | Document number of terminated abortions, if none indicate 0, DO NOT LEAVE BLANK |
| Living | Document number of living children, if none indicate 0, DO NOT LEAVE BLANK |
| Height/Weight/BMI | Document Member's height, weight and BMI |
| Date Last PAP | Document date of last Pap Smear |
| 17P Candidate | Indicate whether Member is a candidate for 17P |
| Depression Screen | Document whether Member was screened for Depression |
| Validated Depression Tool | Document whether a validated depression tool was used. List the name of tool and date administered. |
| Score | Document Member's depression screening score |
| Date Admin. | Document date of depression screening |
| Referral | Document whether Member was referred for treatment for Depression |
| Follow-Up Date | Document the referral follow-up date |
| Dental Visit, last 6 months | Document whether Member had a dental visit in the last 6 months |
| Tubal Desired | Document whether Member desires tubal ligation |
| Consent Signed | Document whether Member signed a consent form for tubal ligation |
| Influenza Vaccine Date | Document date of Member's Influenza Vaccination. Use box for N/A and Refused when appropriate. |
| Tdap Vaccine Date and Gestation | Document date of Member's Tdap vaccination and the gestation week (optional) at the time of vaccination. Use box for N/A and Refused when appropriate. |

| Complete the middle section as follows: | |
|--|---|
| The information requested in the middle of the form allows the MCOs and ACCESS Plus to risk-stratify our members and to make appropriate referrals into our Case Management or Disease Management programs. The Current Risks and Active Medical/Mental Health Conditions sections have been expanded to better identify specific risks that could impact a pregnancy. | |
| Entry | Instructions/Reason to Provide Information |
| Past OB Complications | Identifies members whose past complications increase their risk for current problems; If member has had no Past OB Complications, check No Past OB Complications box in section header. |
| Current Risks | Identifies potential risks for adverse outcomes; If member has had no Current Risks, check No Current Risks box in section header. |
| Active Medical/Mental Health Conditions | Identifies medical/mental health condition related to the mother; If member has had no Active Medical/Mental Health Conditions, check No Active Medical/Mental Health Conditions box in section header. For the following conditions, list specific disease type(s): Autoimmune, Cardiac, Hepatitis, Renal, Sickle Cell, STI, Thyroid. For all others, check Y/N. |
| Social, Economic, Lifestyle | Identifies lifestyle issues that can lead to adverse outcomes; If member has had no Social, Economic, Lifestyle indicators, check No Social, Economic, Lifestyle box in section header. Screen for substance use, if yes whether a validated substance screening tool was used, list the name of tool (4Ps, 4Ps Plus, 5Ps, NIDA Quick Screen, Substance Use Risk Profile Pregnancy (SURP-P) Scale, ASSIST, TICS), date administered, the substance use screening score, and was referral made, referral follow-up date. |
| Delivery | Document date delivered, gestational age at the time of delivery, elective delivery, delivered vaginal or c-section, delivered vertex, birth weight (in grams), if baby was admitted to NICU, is the baby viable and if antenatal steroids were administered. |
| Elective Delivery | Refers to deliveries performed for low-risk pregnancies due to the woman's or provider's choice, not for medical reasons at ≥ 37 weeks and < 39 weeks of gestation completed. |
| Postpartum Visit | Document the date of the visit, list the visit type via telehealth (phone or conferencing) or home health visits, screen for postpartum depression, if yes whether a validated depression tool was used, list the name of tool and date administered, the depression screening score, and was referral made, referral follow-up date, and feeding method, whether contraception discussed and plan, postpartum diabetes testing, whether quit tobacco during pregnancy and whether remains tobacco free. |
| Prenatal Visit Dates | Complete for all visits after the first visit (first visit is already documented in the demographics section). |
| Attach additional information if necessary | |

Questions regarding the form contact:

**Department of Human Services
Bureau of Fee for Service Programs**
Attn: Intense Medical Case Management Unit
Commonwealth Towers
303 Walnut Street, 9th Floor
Harrisburg, PA 17101
Phone: 1-800-537-8862
Fax: 717-705-8391

**AmeriHealth Caritas Northeast –
New East Zone
Bright Start Program**
8040 Carlson Drive, Suite 500
Harrisburg, PA 17112
Phone: 1-888-208-9528
Fax: 1-855-809-9205

**Health Partners Of Philadelphia
Baby Partners Program**
901 Market Street, Suite 500
Philadelphia, PA 19107
Phone: 215-967-4690
Fax: 215-967-4492

**Aetna Better Health
Special Needs Case Management**
2000 Market Street, Suite 850
Philadelphia, PA 19103
Phone: 215-282-3521
Fax: 877-683-7354

**Gateway HealthSM
MOM Matters Program[®]**
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222
Phone: 1-800-392-1147
Fax: 1-888-225-2360

**Keystone First Health Plan
Bright Start Program**
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-800-521-6867
Fax: 1-877-353-6913

**Geisinger Health Plan Family
Right From the Start Program**
100 North Academy Avenue
Danville, PA 17822-3220
Phone: 570-271-5108
Fax: 570-214-1583

**United Healthcare for Families
Healthy First Steps**
2 Allegheny Center, Suite 600
Pittsburgh, PA 15212
Phone: 1-800-599-5985
Fax: 1-877-353-6913

**AmeriHealth Caritas Pennsylvania -
Lehigh/Capital and New West Zone
Bright Start Program**
8040 Carlson Drive, Suite 500
Harrisburg, PA 17112
Phone: 1-877-364-6797
Fax: 1-866-755-9935

**UPMC Health Plan
Maternity Program**
U.S. Steel Tower 37th Floor
600 Grant Street
Pittsburgh, PA 15219
Phone: 1-866-778-6073
Fax: 412-454-8558

OBSTETRICAL NEEDS ASSESSMENT FORM (ONAF)

OB/GYN Office Information

Practice Name Phone Fax Provider Promise ID
 Initial Submission 28-32 Wks Submit Date Post Partum Submit Date Phone Form Completed by

Mother's Information

First Name Last Name DOB Age
 MAID# Member's Health Plan Healthy Beginnings Plus Member? Yes No Home Phone
 Alternate Phone Language(s) Hospital for Delivery Prenatal Visit
 Best EDC LMP of by US Date GA at 1st Visit Gravida Full Term Pre-Term
 SAB TAB Living Height Weight BMI Date/Last PAP N/A Refused
 Date/Last Chlamydia Screen N/A Refused 17P Candidate? Yes No Depression Present? Yes No
 Validated Depression Tool Used? List: Score Date Referral Yes No Follow-up Date
 Dental Visit Last 6 Months? Yes No Tubal Desired? Yes No Consent Signed? Yes No Influenza Vaccine Date N/A Refused
 Tdap Vaccine Date N/A Refused Gestational Week at Tdap administered

Tobacco Information

Tobacco (Tob.) Use Yes No Tob. Counseling? Yes No Tob. Counseling Received? Yes No Exposure to Environmental Smoke? Yes No
 Counseling for Environmental Smoke? Yes No Electronic Cigarettes? Yes No NRT Offered? Yes No
 Average # of Cigarettes Smoked/Day (If none, enter 0; 1 pack = 20 cigarettes) Pre-Pregnancy 1st Trimester 2nd Trimester 3rd Trimester

| Past OB Complications | Current Risks | Trimester | | | Active Medical/Mental Health Conditions | Yes | No |
|--|--|-----------|-----|-----|---|--|-----------------------|
| | | 1st | 2nd | 3rd | | | |
| <input type="checkbox"/> No Past OB Complications | <input type="checkbox"/> No Current Risks | | | | <input type="checkbox"/> No Active Medical/Mental Health Conditions | | |
| <input type="checkbox"/> Postpartum Depression | <input type="checkbox"/> Hx Leep/Cone Biopsy | | | | Autoimmune Disease(s): | | |
| <input type="checkbox"/> RH Incompatibility | Late and/or Inconsistent Prenatal Care | | | | Anemia HB<10 | | |
| <input type="checkbox"/> Hx of DVT/PE | Abnormal Ultrasound | | | | Asthma | | |
| <input type="checkbox"/> Gestational Diabetes | Abnormal Placenta | | | | Cardiac Disease: | | |
| <input type="checkbox"/> Cervical Insufficiency | Gestational Diabetes | | | | Chronic Hypertension, Pregestational | | |
| <input type="checkbox"/> IUGR | 2nd/3rd Trimester Bleeding | | | | Diabetes, Pregestational | | |
| <input type="checkbox"/> Pregnancy Induced Hypertension (PIH) | Multiple Gestation <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Hepatitis Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <input type="checkbox"/> Premature ROM | Periodontal Disease | | | | Thalassemia <input type="checkbox"/> Alpha <input type="checkbox"/> Beta | | |
| <input type="checkbox"/> Premature Labor/Delivery < 32 wks | Poor Weight Gain | | | | HIV | | |
| <input type="checkbox"/> Preterm Labor/Delivery 32-36 wks | IUGR | | | | Renal Disease: | | |
| <input type="checkbox"/> Fetal Demise/Hx 2nd/3rd Tri Loss | PIH | | | | Seizure Disorder | | |
| <input type="checkbox"/> Previous C-Section # <input type="text"/> | Preterm Dilatation of Cervix/Preterm Labor | | | | Sickle Cell Disease <input type="checkbox"/> Trait <input type="checkbox"/> Disease | | |
| Classical Incision: <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous delivery w/in 1 yr of EDC | | | | Depression: | | |
| Prenatal Visits | Social, Economic, Lifestyle | 1st | 2nd | 3rd | Eating Disorder: | | |
| | <input type="checkbox"/> No Social, Economic, Lifestyle | | | | Bipolar: | | |
| | Mental/Physical/Sexual Abuse Hx <input type="checkbox"/> | | | | Schizophrenia: | | |
| | Housing Insecurity | | | | STI: | | |
| | Food Insecurity | | | | Thyroid: Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Special Needs/Challenges | | | | Other Conditions: | | |
| | Substance Use Disorder ETOH Hx <input type="checkbox"/> | | | | Delivery Date: _____ at _____ Wks Gestation Elect. Del. <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Opioid Hx <input type="checkbox"/> | | | | <input type="checkbox"/> VBAC <input type="checkbox"/> Vag <input type="checkbox"/> C/S Birth Weight: | | |
| | Marijuana/THC Hx <input type="checkbox"/> | | | | NICU Admit <input type="checkbox"/> Yes <input type="checkbox"/> No Viable <input type="checkbox"/> Yes <input type="checkbox"/> No Antenatal Steroids <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Other Hx <input type="checkbox"/> | | | | | | |
| | Specify Other: _____ | | | | Postpartum Visit (Between 1-84 days after delivery) | | |
| | Opioid Therapy: | | | | Visit Date: _____ | Visit Type? List: _____ | |
| | Substance Use Screen? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Feeding Method: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both | Contraceptive Plan: _____ | |
| | Validated Substance Tool Used? List: _____ | | | | PP Depression Present? <input type="checkbox"/> Yes <input type="checkbox"/> No | Validated Depression Tool Used? List: _____ | Score: _____ |
| | Date Administered: _____ | | | | Score: _____ | | |
| | Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Date Admin: _____ | Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No | Follow-Up Date: _____ |
| | Follow-Up Date: _____ | | | | PP Diabetes Testing (PPDM) <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | Quit Tob. During Preg. <input type="checkbox"/> Yes <input type="checkbox"/> No Remains Tob. Free <input type="checkbox"/> Yes <input type="checkbox"/> No | | |



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Physician Signature _____ Date Signed _____