OBSTETRICAL NEEDS ASSESSMENT FORM (ONAF) – INSTRUCTIONS FOR COMPLETION

This form is intended for Medicaid Recipients participating in a HealthChoices 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 MAID# (13-digits)	Document provider's individual/group identification # including address locator
Date initially faxed	Document date accordingly
28-32 week fax date	Document date accordingly
Postpartum (PP) fax 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)
Mem ID/MAID#	Document MCO Member ID# or 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℠, Geisinger Health Plan, Health Partners, Keystone First Health Plan, United Healthcare Community Plan, 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
AB	Document number of abortions, if none indicate 0, DO NOT LEAVE BLANK
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
Date Last Chlamydia Screen	Document date of last Chlamydia screen
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.
Result	Document whether Member screened positive or negative for Depression
Referral	Document whether Member was referred for treatment for Depression
Dental Visit, last 6 months	Document whether Member had a dental visit in the last 6 months

Complete the middle section as follows:

The information requested in the middle of the form allows the MCOs 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, STD, 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.
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.
Postpartum Visit	Document the date of the visit, screen for post partum depression, if yes whether a validated depression tool was used, list the name of tool and date administered, and was referral made, feeding method, whether contraception discussed and plan, 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
1006 Hemlock Drive
Willow Oak Building – DGS Annex Complex
Harrisburg, PA 17110-3595
Phone: 1-800-537-8862 or 717-772-6777
Fax: 717-265-8030

Aetna Better Health
Bright Expectations Program
2000 Market Street, Suite 850
Philadelphia, PA 19103
Phone: 855-346-9828
Fax: 877-683-7354

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

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

Gateway Health℠
MOM Matters Program®
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222
Phone: 1-800-642-3550 - Option 2
Fax: 1-888-225-2360

Geisinger Health Plan Family
Right From the Start Program
100 North Academy Avenue
Danville, PA 17822-3236
Phone: 1-866-847-1216
Fax: 570-214-1380

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

Keystone First Health Plan
Bright Start Program
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-800-521-6867
Fax: 1-866-405-7946

United Healthcare Community Plan
Healthy First Steps
2 Allegheny Center, Suite 600
Pittsburgh, PA 15221
Phone: 1-800-599-5985
Fax: 1-877-353-6913

UPMC for You
UPMC for a New Beginning
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 ____ MAID ____

Date Initially Faxed ____ 28-32 Wks Fax Date ____ Postpartum Fax Date ____ Form Completed By ____

Member's Information:

First Name ____ Last Name ____ DOB ____ Age ____

Mem.ID/MAID# ____ Member's Health Plan ____ Healthy Beginnings Plus Member? ☐ Yes ☐ No Home Phone ____

Alternate Phone ____ Language(s) ____ Hospital for Delivery ____ 1st Prenatal Visit ____

EDC ____ ☐ by LMP of ____ ☐ by US Date ____ GA at 1st Visit ____ Gravida ____ Full Term ____ Pre-Term ____

AB ____ SAB ____ TAB ____ Living ____ Height ____ Weight ____ BMI ____ Date/Last PAP ____ Date/Last Chlamydia Screen ____

17P Candidate? ☐ Yes ☐ No Depression Screen? ☐ Yes ☐ No Result: ☐ Positive ☐ Negative Validated Depression Tool Used? List: ____ Date Admin: ____ Referral? ☐ Yes ☐ No

Dental Visit Last 6 Months? ☐ Yes ☐ No

Tobacco (Tob.) Use Average # of Cigarettes Smoked/Day (If none, enter 0; 1 pack = 20 cigarettes) Pre-Pregnancy ____ 1st Trimester ____ 2nd Trimester ____ 3rd Trimester ____

Tob. Counseling Offered? ☐ Yes ☐ No Tob. Counseling Received? ☐ Yes ☐ No Exposure to Environmental Smoke? ☐ Yes ☐ No Counseling for Environmental Smoke? ☐ Yes ☐ No

Past OB Complications
☐ **No Past OB Complications**
☐ Postpartum Depression
☐ RH Incompatibility
☐ Hx of DVT/PE
☐ Gestational Diabetes
☐ Cervical Insufficiency
☐ IUGR
☐ Pregnancy Induced Hypertension (PIH)
☐ Premature ROM
☐ Preterm Labor/Delivery < 32 wks
☐ Preterm Labor/Delivery 32 - 36 wks
☐ Fetal Demise/Hx 2nd/3rd Tri Loss
☐ Previous C-Section #
Classical incision: ☐ Yes ☐ No

Current Risks	Trimester 1st	2nd	3rd
☐ **No Current Risks**			
☐ Hx Leep/Cone Biopsy			
Late and/or inconsistent prenatal care	☐	☐	☐
Abnormal Ultrasound	☐	☐	☐
Abnormal Placenta:	☐	☐	☐
Gestational Diabetes	☐	☐	☐
2nd/3rd Trimester Bleeding		☐	☐
Multiple Gestation ☐ Yes ☐ No			
Periodontal Disease	☐	☐	☐
Poor Weight Gain	☐	☐	☐
IUGR	☐	☐	☐
PIH	☐	☐	☐
Preterm Dilation of cervix/preterm labor	☐	☐	☐
Previous delivery w/in 1 yr of EDC	☐	☐	☐

Active Medical/Mental Health Conditions	Yes	No
☐ **No Active Medical/Mental Health Conditions**		
Autoimmune Disease(s):	☐	☐
Anemia Hb < 10	☐	☐
Asthma	☐	☐
Cardiac Disease:	☐	☐
Chronic Hypertension, Pregestational	☐	☐
Diabetes, Pregestational	☐	☐
Hepatitis:	☐	☐
HIV	☐	☐
Schizophrenia	☐	☐
Renal Disease:	☐	☐
Seizure Disorder	☐	☐
Sickle Cell Disease: ☐ Trait ☐ Disease	☐	☐
☐ Depression ☐ Bipolar	☐	☐
STD:	☐	☐
Thyroid: Treated: ☐ Yes ☐ No	☐	☐

Other Conditions:

Prenatal Visits	

Social, Economic, Lifestyle		1st	2nd	3rd
☐ **No Social, Economic, Lifestyle**				
Mental/Physical/Sexual Abuse	☐ Hx	☐	☐	☐
Intellectual Impairment		☐	☐	☐
Homelessness		☐	☐	☐
Eating Disorder:		☐	☐	☐
Substance Abuse	☐ ETOH ☐ Hx	☐	☐	☐
	☐ Rx ☐ Hx	☐	☐	☐
	☐ Street ☐ Hx	☐	☐	☐
Opioid Therapy		☐	☐	☐

Delivery: Date ____ at ____ Weeks Gestation Elective Del. ☐ Yes ☐ No

☐ Vag ☐ C/S Vertex ☐ Yes ☐ No Birth Wgt: ____

☐ NCIU Admission Viable: ☐ Yes ☐ No Antenatal Steroids ☐ Yes ☐ No

Postpartum Visit (Between 21-56 days after delivery)

Visit ____ Feeding Method: ☐ Breast ☐ Bottle ☐ Both

PP Contraception Discussed: ☐ Yes ☐ No Contraception Plan ____

PP Depression Present: ☐ Yes ☐ No

Validated Depression Tool Used? List: ____ Date Admin: ____

Referral: ☐ Yes ☐ No

Quit Tob. During Preg. ☐ Y ☐ N Remains Tob. Free ☐ Y ☐ N

Physician Signature

Date Signed

pennsylvania
DEPARTMENT OF HUMAN SERVICES