**Care Management for High-Risk Pregnancies (CMHRP)**  
Pregnancy Risk Screening Form

*Practice Name: ________________________________

Practice Phone Number: ________________________________

*Today’s Date: _____ / _____ / ______

Date of next prenatal appointment: _____ / _____ / ______

First name: ______________________ MI ____________________ Last name: ____________________

*EDC: _____ / _____ / ______

**OBSTETRIC HISTORY**

− Preterm birth (<37 completed weeks)
− Gestational age(s) of previous preterm birth(s):
  weeks, weeks, weeks
− At least one spontaneous preterm labor and/or rupture of the membranes
  *If this is a singleton gestation, this patient is eligible for 17P treatment.
− Low birth weight (<2500g)
− Fetal death >20 weeks
− Neonatal death (within first 28 days of life)
− Second trimester pregnancy loss
− Three or more first trimester pregnancy losses
− Cervical insufficiency
− Gestational diabetes
− Postpartum depression
− Hypertensive disorders of pregnancy
  − Eclampsia
  − Preeclampsia
  − Gestational hypertension
  − HELLP syndrome

- Provider requests care management
  Reason(s): __________________________________________

Provider Comments/Notes: __________________________________________

*For LHD Use Only: Date RSF was received: ____________________

*Date RSF was entered: ____________________

*Required fields
Version 2 (Rev. 12/01/2020) Submit completed form to the CMHRP staff at the local health department in the patient’s county of residence.
Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Complete this side of the form as honestly as possible and give it to your nurse or doctor. The information you provide allows us to coordinate services with the care manager and provide the best care for you and your baby.

| Name: _______________________________ | Date of birth: _________________ | Today's date: ____________ |
| Physical Address: ____________________ | City: _________________________ | ZIP: ________________ |
| Mailing Address (if different): _______ | City: _________________________ | ZIP: ________________ |
| County: __________________ Home phone number: ________________ | Work phone number: ________________ |
| Cell phone number: __________________ | Social security number (if available): __________________ |

**Race:**
- ☐ American-Indian or Alaska Native
- ☐ Asian
- ☐ Black/African-American
- ☐ Pacific Islander/Native Hawaiian
- ☐ White
- ☐ Other (specify): _______________________

**Ethnicity:**
- ☐ Not Hispanic
- ☐ Cuban
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Other Hispanic

**Education:**
- ☐ Less than high school diploma
- ☐ GED or high school diploma
- ☐ Some college
- ☐ College graduate

1. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
   - ☐ I wanted to be pregnant sooner
   - ☐ I wanted to be pregnant now
   - ☐ I wanted to be pregnant later
   - ☐ I did not want to be pregnant then or any time in the future
   - ☐ I don’t know

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?  ☐ Yes ☐ No

3. Are you in a relationship with a person who threatens or physically hurts you?  ☐ Yes ☐ No

4. Has anyone forced you to have sexual activities that made you feel uncomfortable?  ☐ Yes ☐ No

5. In the last 12 months were you ever hungry but didn’t eat because you couldn’t afford enough food?  ☐ Yes ☐ No

6. Is your living situation unsafe or unstable?  ☐ Yes ☐ No

7. Which statement best describes your smoking status? Check one answer.
   - ☐ I have never smoked, or have smoked less than 100 cigarettes in my lifetime
   - ☐ I stopped smoking BEFORE I found out I was pregnant and am not smoking now
   - ☐ I stopped smoking AFTER I found out I was pregnant and am not smoking now
   - ☐ I smoke now but have cut down some since I found out I was pregnant
   - ☐ I smoke about the same amount now as I did before I found out I was pregnant

8. Did any of your parents have a problem with alcohol or other drug use?  ☐ Yes ☐ No

9. Do any of your friends have a problem with alcohol or other drug use?  ☐ Yes ☐ No

10. Does your partner have a problem with alcohol or other drug use?  ☐ Yes ☐ No

11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?  ☐ Yes ☐ No

12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?
   - ☐ Not at all
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Frequently

13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?
   - ☐ Not at all
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Frequently

*Required fields
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