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**WNY COLLABORATIVE
PRENATAL CARE RISK SCREENING and REFERRAL FORM**

Member Last Name _____ Member First Name _____ Member ID #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ____/____/____ Work/Cell phone: ____/____/____ DOB: ____/____/____
MM DD YYYY

PNC Provider Information

Last Name: _____ First Name: _____

Address: _____ Provider ID #: _____

Tax ID #: _____ Phone: ____/____/____ Provider FAX: ____/____/____

Pregnancy information:

Initial Visit Date ____/____/____ Gestational Age (weeks) _____ by LMP **OR** by Ultra sound
MM DD YYYY

Entry into PNC Gravida: ____ Para: ____ LMP ____/____/____ EDC ____/____/____
MM DD YYYY MM DD YYYY

Height _____ Weight _____

Demographic information: Choose ALL that apply.

Race/ethnicity: Caucasian Black or African American Asian American Indian Other
Primary Language: English Spanish Other (specify) _____ Hispanic: ____ Yes / ____ No

Pregnancy Risk Factors: Check all risk factors that apply.

<input type="checkbox"/> <input type="checkbox"/> Abdominal surgery	<input type="checkbox"/> <input type="checkbox"/> Pre-term labor	<input type="checkbox"/> <input type="checkbox"/> Fetal abnormality	<input type="checkbox"/> <input type="checkbox"/> <16 yr or > 35
<input type="checkbox"/> <input type="checkbox"/> C-Section	<input type="checkbox"/> <input type="checkbox"/> Preterm birth <37 wks	<input type="checkbox"/> <input type="checkbox"/> Multiple gestation	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Cervical incompetence	<input type="checkbox"/> <input type="checkbox"/> LBW <2500gms 5½lbs	<input type="checkbox"/> <input type="checkbox"/> HTN/Preeclampsia	<input type="checkbox"/> <input type="checkbox"/> Alcohol use
<input type="checkbox"/> <input type="checkbox"/> Placenta Abruption	<input type="checkbox"/> <input type="checkbox"/> Bt wt >4500gms/10lbs	<input type="checkbox"/> <input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> <input type="checkbox"/> Drug use
<input type="checkbox"/> <input type="checkbox"/> Placenta Previa	<input type="checkbox"/> <input type="checkbox"/> Stillborn/fetal death	<input type="checkbox"/> <input type="checkbox"/> STDs _____	<input type="checkbox"/> <input type="checkbox"/> Tobacco use

Medical Risk Factor: Check all risk factors that apply.

<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Eating disorder
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> DVT/Pulmonary Embolism	<input type="checkbox"/> <input type="checkbox"/> Kidney disease	<input type="checkbox"/> <input type="checkbox"/> Underweight
<input type="checkbox"/> <input type="checkbox"/> Auto-Immune disorder	<input type="checkbox"/> <input type="checkbox"/> Dental problem	<input type="checkbox"/> <input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> <input type="checkbox"/> Overweight/Obese
<input type="checkbox"/> <input type="checkbox"/> Cardiac history	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/> Lead Exposure

Psycho-Social Risk Factors: Check all risk factors that apply.

<input type="checkbox"/> Unmarried/NO partner	<input type="checkbox"/> Unemployed (patient)	<input type="checkbox"/> Physical disability	<input type="checkbox"/> Unplanned pregnancy	<input type="checkbox"/> Yes On Meds
<input type="checkbox"/> No family support	<input type="checkbox"/> Husband/partner unemployed	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Children in foster care	<input type="checkbox"/> <input type="checkbox"/> Psychiatric diagnosis
<input type="checkbox"/> Unstable housing	<input type="checkbox"/> Education<12 yrs	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Language barrier	
<input type="checkbox"/> Homeless	<input type="checkbox"/> Transportation problem	<input type="checkbox"/> Risk of self harm		
<input type="checkbox"/> No phone	<input type="checkbox"/> Mental disability	<input type="checkbox"/> Domestic violence		

Referrals Made: Check actions taken by the provider &/or those refused by the patient

<input type="checkbox"/> <input type="checkbox"/> Community Case Manager	<input type="checkbox"/> <input type="checkbox"/> High Risk OB	<input type="checkbox"/> <input type="checkbox"/> Asthma Educator	<input type="checkbox"/> <input type="checkbox"/> WIC
<input type="checkbox"/> <input type="checkbox"/> Health Plan Case Manager	<input type="checkbox"/> <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> <input type="checkbox"/> Diabetes Educator	<input type="checkbox"/> <input type="checkbox"/> Nutrition Counseling
<input type="checkbox"/> <input type="checkbox"/> Behavioral/ Mental Health	<input type="checkbox"/> <input type="checkbox"/> Tobacco Cessation Program	<input type="checkbox"/> <input type="checkbox"/> Home Visit Provider	<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/> <input type="checkbox"/> Domestic Violence	<input type="checkbox"/> <input type="checkbox"/> Dental Care	<input type="checkbox"/> <input type="checkbox"/> Supplemental Nutrition Assistance Program (Food Stamps)	

1) Does your patient want assistance with linkage or referral to services? YES NO
2) Do you want assistance with linkage or referral of your patient to services? YES NO

Name: _____ Title: _____
Provider/team member completing form (please print)

Current Pregnancy Risk: High At-Risk Low

Consent for Release of Information

Patient Name: _____
Last First Middle

Date of Birth: _____ Managed Care Plan: _____

Enrolled in Medicaid: YES NO County: _____

CIN # _____

Check all that apply:

- I authorize my health care provider, (name of health care provider) to release my confidential information listed on the New York State Prenatal Care Risk Form and any information provided during my evaluation by my health care provider to (name of coordinator) for the purposes of coordination of care, payment of claims for services, quality improvement of services, screening for program eligibility, and care and treatment.
- I authorize release of my confidential information listed on the New York State Prenatal Care Risk Form by (name of coordinator) to any or all of the following providers or organizations that may be providing care or services to me, as applicable: my managed care plan, my health care providers, my county health department, agencies or organizations providing prenatal services or other social or family health services including but not limited to those listed on Attachment A of this consent form.
- I understand that my confidential information may include HIV/AIDS, mental health, adult/child abuse or alcohol/substance abuse information about me. I hereby give my consent to the release of such information to the (name of coordinator) and entities or organizations listed above that will be providing care or services to me. I understand that any disclosure of the records of Federally assisted alcohol or drug abuse treatment programs is bound by Title 42 of the Code of Federal Regulations.

I understand that this consent for release of information is voluntary, and that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for a managed care plan's eligibility or enrollment determinations relating to me.

I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

I understand that the recipient of my confidential information may not be required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and therefore the recipient of my confidential information may re-disclose it.

I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I can withdraw my consent by notifying (name of coordinator) in writing at the following address:

If not previously revoked, this consent shall expire one year from its signing.

Patient's Signature Date

Witness Signature Date

Print Patient's Name

Signature of Personal Representative of Patient