

# Obstetrical Needs Assessment (ONAF)

**Fax Information** *(please fax updated form after each visit)*

 AmeriChoice of PA fax: 215-832-4986   
 Health Partners fax: 215-967-4492   
 Keystone Mercy Health Plan fax: 1-866-405-7946 

Initial fax date: \_\_\_/\_\_\_/\_\_\_ Post partum fax date: \_\_\_/\_\_\_/\_\_\_

**Member Information**

 FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
 LAST NAME \_\_\_\_\_  
 Date of birth (mo/day/year) \_\_\_/\_\_\_/\_\_\_ Member ID# or MA recipient# \_\_\_\_\_  
 Home phone # \_\_\_\_\_ Alternate phone # \_\_\_\_\_  
 Hospital for delivery \_\_\_\_\_ weeks  
 Gestational age 1<sup>st</sup> visit \_\_\_\_\_

**Provider Information**

 PROVIDER # \_\_\_\_\_  
 PRACTICE NAME: \_\_\_\_\_  
 Practice Phone Number: \_\_\_\_\_  
 Practice Fax Number: \_\_\_\_\_

 Date of 1<sup>st</sup> prenatal visit \_\_\_/\_\_\_/\_\_\_ EDC date \_\_\_/\_\_\_/\_\_\_ Gravida T \_\_\_ P \_\_\_ Tab \_\_\_ Sab \_\_\_ L \_\_\_ Yes \_\_\_ No \_\_\_  
 17P candidate?

 Date of last pap \_\_\_/\_\_\_/\_\_\_ Date last chlamydia screen \_\_\_/\_\_\_/\_\_\_ Depression screen? \_\_\_ Yes \_\_\_ No \_\_\_  
 Dental visit past 6 mos.? \_\_\_ Yes \_\_\_ No \_\_\_ In Healthy Beginnings? \_\_\_ Yes \_\_\_ No \_\_\_

Past OB Complications	Current Risks	(Please ✓) Trimester			Active Maternal Medical Disorders	(Please ✓) Trimester		
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>
<input type="checkbox"/> Gestational Diabetes	2 <sup>nd</sup> /3 <sup>rd</sup> trimester bleeding				Anemia HB<10			
<input type="checkbox"/> Incompetent cervix	Abnormal ultrasound				Asthma			
<input type="checkbox"/> IUGR	Gestational diabetes				Cardiac disease (specify)			
<input type="checkbox"/> Preeclampsia/Eclampsia	Late and/or inconsistent prenatal care				Chronic hypertension			
<input type="checkbox"/> Premature ROM	Perinatal depression				Clotting disorder (specify)			
<input type="checkbox"/> Preterm delivery <32 wks	Periodontal disease				Diabetes			
<input type="checkbox"/> Preterm delivery 32-36 wks	Multiple gestation				Hepatitis (specify)			
<input type="checkbox"/> Preterm labor <32 wks	Preeclampsia/Eclampsia				HIV			
<input type="checkbox"/> Previous C-Section	Premature ROM				Renal disease (specify)			
<input type="checkbox"/> Recurrent 2 <sup>nd</sup> trimester loss	Preterm dilation of cervix (>1.5 cm) or Preterm Labor, < 32 weeks or cerclage				Seizure disorder			
<b>Prenatal Visit Dates</b>	Previous delivery within 1 year				Sickle cell disease			
___/___/___	Other				STD (specify)			
___/___/___	<b>Social, Economic, Lifestyle Risks</b>				Thyroid disease (specify)			
___/___/___	Currently using tobacco				Cervical surgery			
___/___/___	Cessation services offered				Other medical issues			
___/___/___	Exposure to other smoke							
___/___/___	Eating disorder (specify) _____				<b>Postpartum Visit</b> (should be between 21-56 days after delivery)			
___/___/___	Mental, physical or sexual abuse				Date of delivery	___/___/___		
___/___/___	Homelessness				Type of delivery	Vag ___ C-Sec ___		
___/___/___	Mental health disorder/history of depression				Date of postpartum visit	___/___/___		
___/___/___	Mental retardation				Feeding method	Breast ___ Bottle ___ Both ___		
___/___/___	English as a second language				Postpartum depression present			
___/___/___	Substance abuse: ETOH Street or Rx Drugs				Referral for behavioral health treatment			
___/___/___	Teen pregnancy				Quit tobacco during pregnancy			
___/___/___	Head of household aware				Remains tobacco free			
___/___/___	Other social issues (specify)				Cessation services offered			
___/___/___	Referral for behavioral health treatment				Community referrals made:			

**Physician signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Obstetrical Needs Assessment Form – Instructions for Completion

The Obstetrical Needs Assessment Form (ONAF form) serves as the initial notification of a member’s pregnancy to her Health Plan. Prompt submission from your office allows us to enroll the member into our Maternity Management Programs as early as possible.

- Please fill in the demographics section in its entirety for the first submission.
- Please complete the clinical section in its entirety for each submission by checking the trimester in which the risk or medical condition was noted.
  - Checked boxes indicate that the condition was identified by the provider’s office in that trimester.
  - Unchecked boxes indicate the risk was not identified.
- The ONAF form can also be used to notify us regarding additional prenatal visits and newly identified risk factors. You do not need to complete the top part of the form each time. Simply add the new office visit(s) or risk factor(s) to the original form and fax it again.
- Please fill in the dates of all visits including the post partum visit.
- The ONAF form does not need to be filled out by a physician, but must be signed by a physician.
- Please FAX the ONAF form to the member’s health plan ASAP after the initial office visit in order to enable enrollment into our Pregnancy Case/Care Management Programs.

The clinical information requested on the bottom of the form allows each Plan to risk-stratify our members to make appropriate referrals into our case management/care management programs. The Current Risks and Active Maternal Medical Disorders section was added at the request of Providers who want to let us know what they have already done for the member. This will enable our Maternity Case Managers to better reinforce your treatment plans when they contact the member by telephone.

### Fax Numbers and Phone Numbers for Questions Regarding the ONAF Form

AmeriChoice of PA	Health Partners	Keystone Mercy Health Plan
Fax: 215-832-4986	Fax: 215-967-4492	Fax: 1-866-405-7946
Phone: 1-866-846-2904	Hot Line: 215-991-4182	Phone: 1-800-521-6867
		215-863-5711