

# 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
<b>New</b> 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 <sup>SM</sup> , 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
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 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, 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  
Special Needs Case Management**  
2000 Market Street, Suite 850  
Philadelphia, PA 19103  
Phone: 215-282-3521  
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<sup>SM</sup>  
MOM Matters Program<sup>®</sup>**  
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 17822-3220  
Phone: 570-271-5108  
Fax: 570-214-1583

**Health Partners of Philadelphia  
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 for Families  
Healthy First Steps**  
1001 Brinton Road  
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 41st 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	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="text"/>		
<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="text"/>		
<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: <input type="text"/>		
<input type="checkbox"/> Premature ROM	Periodontal Disease				HIV		
<input type="checkbox"/> Preterm Labor/Delivery < 32 wks	Poor Weight Gain				Schizophrenia		
<input type="checkbox"/> Preterm Labor/Delivery 32 - 36 wks	IUGR				Renal Disease: <input type="text"/>		
<input type="checkbox"/> Fetal Demise/Hx 2nd/3rd Tri Loss	PIH				Seizure Disorder		
<input type="checkbox"/> Previous C-Section # <input type="text"/>	Preterm Dilation 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				<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar		

Prenatal Visits	Social, Economic, Lifestyle	Trimester			STD:	Thyroid:	Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No
		1st	2nd	3rd			
	<input type="checkbox"/> No Social, Economic, Lifestyle						
	Mental/Physical/Sexual Abuse <input type="checkbox"/> Hx						
	Intellectual Impairment				Other Conditions:		
	Homelessness						
	Eating Disorder:				<b>Delivery:</b> Date <input type="text"/> at <input type="text"/> Weeks Gestation <input type="text"/> Elective Del. <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Substance Abuse <input type="checkbox"/> ETOH <input type="checkbox"/> Hx				<input type="checkbox"/> Vag <input type="checkbox"/> C/S Vertex <input type="checkbox"/> Yes <input type="checkbox"/> No Birth Wgt: <input type="text"/>		
	<input type="checkbox"/> Rx <input type="checkbox"/> Hx				<input type="checkbox"/> NCIU Admission Viable: <input type="checkbox"/> Yes <input type="checkbox"/> No Antenatal Steroids <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Street <input type="checkbox"/> Hx						
	Opioid Therapy				<b>Postpartum Visit (Between 21-56 days after delivery)</b>		
					Visit <input type="text"/> Feeding Method: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
					PP Contraception Discussed: <input type="checkbox"/> Yes <input type="checkbox"/> No Contraception Plan <input type="text"/>		
					PP Depression Present: <input type="checkbox"/> Yes <input type="checkbox"/> No		
					Validated Depression Tool Used? List: <input type="text"/> Date Admin: <input type="text"/>		
					Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No		
					Quit Tob. During Preg. <input type="checkbox"/> Y <input type="checkbox"/> N Remains Tob. Free <input type="checkbox"/> Y <input type="checkbox"/> N		

Physician Signature   
 Date Signed



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES