



# Maryland Prenatal Risk Assessment- MDH 4850

*(Refer to the Instructions at the bottom of this document before completing this form)*

**Provider Demographic Information:**

Date of Initial Prenatal Visit/ Form Completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Provider NPI#: \_\_\_\_\_ Site NPI# \_\_\_\_\_  
 Provider Name: \_\_\_\_\_ Provider Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Patient Demographic Information:**

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle I: \_\_\_\_\_  
 DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Preferred Pronouns: \_\_\_\_\_  
 Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Medical Assistance Number (MA): \_\_\_\_\_  
 Current Address: Street \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Best Contact Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Contact Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Communication Barrier: Yes \_\_\_\_ (Requires an Interpreter Y/N) No \_\_\_\_ Primary Language \_\_\_\_\_

**Insurance Status (at time of prenatal visit):**

Uninsured: Y ____ N ____	FFS: Y ____ N ____	Applied for Maryland MA: Y ____ N ____ Date: ____ / ____ / ____
Maryland Medicaid: Y ____ N ____		MCO: _____

**Demographics:**

<u>Biologic Sex</u>	Male ____ Female ____	Other: _____	
<u>Gender Identity</u>	Cisgender: Male ____ Female ____	Other: (Patient's own definition) _____	
<u>Race (check all that apply)</u>	Black or African American ____	Asian ____	American Native ____
	Hispanic ____	Native Hawaiian/Pacific Islander _____	Alaska Native ____
	Non Hispanic White ____	Multiracial ____	Unknown ____
<u>Educational Level:</u>	Highest Grade Completed _____	Currently in School: Yes ____ No ____	GED: Yes ____ No ____
<u>Marital Status:</u>	Married ____	Unmarried ____	Unknown ____
	Separated ____	Divorced ____	

**Obstetric History** Gravida \_\_\_\_ Para \_\_\_\_\_:

#Full Term Births		#Preterm Births		#Ectopic Pregnancies	
#Spontaneous Abortions		#Therapeutic Abortions		#Living Children	

**Entry to Prenatal Care:**

OB Date of Initial Visit	____ / ____ / ____	Trimester of 1st Prenatal visit	____ 1st ____ 2nd ____ 3rd
Previous OB Care	____ / ____ / ____	LMP ____ / ____ / ____	EDC ____ / ____ / ____

**Risk Factor Assessment:**

Psychosocial Risks (Check all that apply)

Mental/Behavioral Health <sup>1</sup>	Overwhelming Anxiety/Stress: Y ___ N ___ Poor Coping Skills: Y ___ N ___ Depression: (Active Diagnosis : Y ___ N ___, Past Hx: Y ___ N ___) Partner Dissatisfaction: Y ___ N ___ Intimate Partner/Family Violence/Abuse: Y ___ N ___ Developmental Disability: Y ___ N ___
Behavioral Health Admissions <sup>2</sup>	Recent Psychiatric Inpatient Admission within <1 year: Y ___ N ___ Admission Diagnosis: _____
Substance Misuse <sup>2</sup>	Drugs and/or Opioid Misuse/Addiction: Y ___ N ___ Drug: _____ Currently in SUD treatment: Methadone _____ Subutex _____ Recent SUD related Inpatient Admission. within <1 year: Y ___ N ___ Exchanging sex for drugs: Y ___ N ___ Nicotine/Tobacco/Vaping use: Y ___ N ___ Amount: _____ Alcohol: Y ___ N ___ Amount ___/day
Financial Insecurity <sup>3</sup>	Currently Unemployed: Y ___ N ___ Temporary Assistance for Needy Families (TANF) eligibility: Y ___ N ___
Social Support/Network <sup>4</sup>	Identified lack of Friends/Family Social Support Network: Y ___ N ___ Housing Insecurity/Homelessness: Y ___ N ___ Lack of Transportation: Y ___ N ___ Child Care Issues: Y ___ N ___ Recent incarceration/Partner currently incarcerated: Y ___ N ___
Nutrition	Food Insecurity/Poor Nutrition: Y ___ N ___
Exercise//Self Care	Lack of regular exercise (30min/day for at least 3x/wk): Y ___ N ___

Medical Risks (Check all that apply)

Maternal Age	Age < or = 16 _____ Age > or = 35 _____
Maternal BMI	BMI < 18.5 _____ or BMI > 30 _____
Sexually Transmitted Infection - STI. (GC/Chlamydia/HIV/Hep B/C or Syphilis)	Current/Recently Treated STI: STI Name: _____ STI screening (including Syphilis) completed for current Pregnancy: Y ___ N ___ Past STI Hx: (Syphilis) _____ (Herpes) _____
Chronic Disease	Asthma: Y ___ N ___ Inhaler Rx: Y ___ N ___ Diabetes Y ___ N ___: If yes then Treatment Medication: _____ Chronic HTN/Heart Disease: Y ___ N ___ Sickle Cell Disease: Y ___ N ___ Sickle Cell Trait: Y ___ N ___ Anemia - HCT < 33 or HGB < 11: Y ___ N ___ Lab Result _____ Autoimmune Disorder: Y ___ N ___ If yes please name: _____ H/O - Thrombophilias/DVT: If yes please describe: _____

Dental Care	Last Dental visit >1 year. Y ___ N ___
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Pregnancy Risk Factors (Check all that apply)

Identified obstetric risks	Patient's First Pregnancy: Yes ___ No ___ Covid Vaccinated: Yes ___ No ___ Covid Booster Current: Yes ___ No ___ Short Interval Pregnancy <9 Months from last birth: Yes ___ No ___ Late Entry into Care >14 week: Y ___ N ___ Previous H/O Preterm Labor/Birth: Y ___ N ___ H/O Previous Gestational Diabetes: Y ___ N ___ Current multiple gestation pregnancy: Y ___ N ___ H/O previous LBW Baby: Y ___ N ___ H/O previous Fetal Death In Utero >20 weeks: Y ___ N ___ Previous Pregnancy affected with Preeclampsia/Eclampsia/HELLP Syndrome: Y ___ N ___ H/O Cervical Incompetence: Y ___ N ___ H/O Previous infant affected with congenital defect: Y ___ N ___ Define: _____
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**DEFINITIONS (To help complete Risk Assessment)**

<sup>1</sup> Mental/Behavioral Health	Concern for the need of BH Services.
<sup>1</sup> Intimate Partner/Family Violence/Abuse	Physical, psychological abuse or violence within the patient's environment.
<sup>1</sup> Exposure to long-term stress	Partner-related, financial, personal, emotional.
<sup>2</sup> Substance Misuse	<ul style="list-style-type: none"> <li>Concern for use of illegal substances within the past 6 months.</li> <li>At "risk-drinker" as determined by a screening tool such as T-ACE, CAGE, or AUDIT.</li> </ul>
<sup>3</sup> Financial Insecurity	Example: Unemployed > 3months. Involved in exchanging sex for drugs.
<sup>4</sup> Lack of social/emotional support	Absence of support system i.e. family/friends. Feeling isolated.
Family History/Genetic risk.	At risk for a genetic or hereditary disorder. Known genetic carrier. H/O congenital anomalies.
Communication barrier	In need of an interpreter.
Dental Care	Last Dental Visit > 1year.
Prior Preterm birth	H/O of preterm birth (prior to the 37th gestational age).
Prior LBW birth	Low birth weight birth (under 2,500 grams).

**Maryland Prenatal Risk Assessment Form  
(Instructions for use)**

**Purpose of Form:** Identifies pregnant women who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by nurses, community health and outreach workers and may include education about Medicaid benefits, reinforcement of the medical plan of care, resource linkage and other related services.

**Instructions:** On the initial visit the provider/staff will complete the demographic and assessment sections for pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

- Enter both the provider and site/facility NPI numbers.
- Print clearly; use black pen for all sections.
- If the client does not have a social security number, indicate zeroes.
- Indicate the person completing the form.
- Review for completeness and accuracy.

**Faxing and Handling Instructions:** Fax the MPRA to the local health department in the client's county of residence. To reorder forms call the local ACCU.

Mailing Address (client resides)	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 3 Harry S. Truman Parkway, HD8 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU Healthcare Access Maryland 1 N. Charles St., #900 Baltimore, MD 21201	410-640-5000 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3 <sup>rd</sup> Floor Baltimore, MD 21212	410-887-8741 Fax: 410-828-8346
Calvert County ACCU P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 1-833-662-7942
Caroline County ACCU 403 S. 7th St. Denton, MD 21629	410-479-8189 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St. Westminster, MD 21158-0845	410-876-4941 Fax: 410-876-4949 Email: cchd.accu@maryland.gov
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5130 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway White Plains, MD 20695	301-609-6760 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-901-8167 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3124 Fax: 301-600-3302
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7770 Fax: 301-334-7771

Mailing Address (client resides)	Phone Number
Harford County ACCU 2015 Pulaski Highway, Suite E Havre De Grace, MD 21708	410-942-7999 Fax: 443-502-8975
Howard County ACCU 8930 Stanford Blvd. Columbia, MD 21045	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7035 Fax: 1-844-222-7105
Montgomery County ACCU 1401 Rockville Pike, Suite 2400 Rockville, MD 20852	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 1801 McCormick Drive Suite 280 Largo, MD 20774	301-856-9550 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4456 Fax: 443-262-9357
St. Mary's County ACCU 21580 Peabody St. Leonardtown, MD 20650	301-475-4330 Fax: 301-309-4117
Somerset County ACCU 8928 Sign Post Road Westover, MD 21871	443-523-1758 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6964
Worcester County ACCU 9730 Healthway Drive Berlin, MD 21811	410-629-0164 Fax: 410-629-0185