

OB REGISTRATION FORM

*Complete and return this form for all obstetrical patients assigned to VPHP, Inc. Information is used by care management teams to educate members and coordinate care. **Please Fax This Form Back To VPHP, Inc. @ (800) 827-7192***

Patient Information																			
Member's Name:		Age:	Date of Birth:																
Current Address:			VPHP ID#																
Patient's Phone Numbers: (Home)		(Cell)	Today's Date :																
Alternate Phone Number:																			
Provider Information																			
Name of Facility:	Name of Obstetrician:	NPI Number:	Phone Number:	Fax Number:															
Patient History																			
Current Weight:	Pre-Pregnancy Weight	Height:	Last Menstrual Period:	Sonogram Performed:															
Date Prenatal Care Initiated:		Gravida:	Para:	EDC:															
		Live Births:	Ectopic:																
Risk Assessment																			
☐ Planned C-Section Indication: _____ Smoker Substance Abuse If yes, list: _____ HIV/AIDS STD IF yes, list: _____ IUGR Incompetent Cervix Other: _____ Do you consider this a High Risk Pregnancy? If yes, explain: _____ Additional Comments: _____ _____ _____ _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d3d3d3;"> <th style="text-align: center; padding: 5px;">Previous Adverse Pregnancy Outcomes</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">☐ Premature Births</td></tr> <tr><td style="padding: 5px;">☐ Stillbirths</td></tr> <tr><td style="padding: 5px;">☐ Fetal Death</td></tr> <tr><td style="padding: 5px;">☐ Fetal Abnormalities</td></tr> <tr><td style="padding: 5px;">☐ Fetal Complications</td></tr> <tr><td style="padding: 5px;">☐ Abortion</td></tr> <tr><td style="padding: 5px;">☐ Other: _____</td></tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d3d3d3;"> <th style="text-align: center; padding: 5px;">Current Pregnancy Complications</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">Maternal Bleeding</td></tr> <tr><td style="padding: 5px;">Preeclampsia</td></tr> <tr><td style="padding: 5px;">Diabetes</td></tr> <tr><td style="padding: 5px;">Hypertension</td></tr> <tr><td style="padding: 5px;">Nutritional Deficit</td></tr> <tr><td style="padding: 5px;">Other: _____</td></tr> </tbody> </table>			Previous Adverse Pregnancy Outcomes	☐ Premature Births	☐ Stillbirths	☐ Fetal Death	☐ Fetal Abnormalities	☐ Fetal Complications	☐ Abortion	☐ Other: _____	Current Pregnancy Complications	Maternal Bleeding	Preeclampsia	Diabetes	Hypertension	Nutritional Deficit	Other: _____
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Virginia Premier Health Plan, Inc

Contact us:
 P.O. Box 5307 Richmond, VA 23220-
 Fax to Medical Management: 1-800-827-7192
 For Medical Management questions call toll free:
 1-888-251-3063
 All other questions call toll free: 1-800-727-7536