OBSTETRICAL NEEDS ASSESSMENT FORM (ONAF)

OB/GYN Office Information

Practice Name | Phone | Fax | Provider Promise ID

Initial Submission Date | 28-32 Wks Submit Date | Post Partum Submit Date | Form Completed by

Member's Information

First Name | Last Name | DOB | Age

MAID# | Member's Health Plan | Healthy Beginnings Plus Member? ☐ Yes ☐ No | Home Phone

Alternate Phone | Language(s) | Hospital for Delivery | Prenatal Visit

Best EDC | ☐ LMP of | ☐ by US Date | GA at 1st Visit | Gravida | Full Term | Pre-Term

SAB | TAB | Living | Height | Weight | BMI | Date/Last PAP | N/A ☐ Refused ☐ | Date/Last Chlamydia Screen | N/A ☐ Refused ☐

17P Candidate? ☐ Yes ☐ No | Depression Present? ☐ Yes ☐ No | Validated Depression Tool Used? List: | Score | Date | Referral: ☐ Yes ☐ No | Follow-Up Date:

Dental Visit Last 6 Months? ☐ Yes ☐ No | Tubal Desired? ☐ Yes ☐ No | Consent Signed? ☐ Yes ☐ No | Influenza Vaccine Date | N/A ☐ Refused ☐ | Tdap Date | N/A ☐ Refused ☐ | Gestational Wk at Tdap admin

Tobacco (Tob.) Use ☐ Yes ☐ No | Tob. Counseling? ☐ Yes ☐ No | Tob. Counseling Received? ☐ Yes ☐ No | Exposure to Environmental Smoke? ☐ Yes ☐ No | Counseling for Environmental Smoke? ☐ Yes ☐ No

Electronic Cigarettes? ☐ Yes ☐ No | NRT Offered? ☐ Yes ☐ No | Average # of Cigarettes Smoked/Day (If none, enter 0; 1 pack = 20 Cigarettes | Pre-Pregnancy | 1st Trimester | 2nd Trimester | 3rd Trimester

Past OB Complications	Current Risks	Trimester 1st	2nd	3rd	Active/Medical/Mental Health Conditions	Yes	No
☐ No Past OB Complications	☐ No Current Risks				☐ No Active Medical/Mental Health Conditions		
☐ Postpartum Depression	☐ HX Leep/Cone Biopsy				Autoimmune Disease(s):	☐	☐
☐ RH Incompatibility	Late and/or Inconsistent Prenatal Care	☐	☐	☐	Anemia HB<10	☐	☐
☐ Hx of DVT/PE	Abnormal Ultrasound	☐	☐	☐	Asthma	☐	☐
☐ Gestational Diabetes	Abnormal Placenta	☐	☐	☐	Cardiac Disease:	☐	☐
☐ Cervical Insufficiency	Gestational Diabetes	☐	☐	☐	Chronic Hypertension, Pregestational	☐	☐
☐ IUGR	2nd/3rd Trimester Bleeding		☐	☐	Diabetes, Pregestational	☐	☐
☐ Pregnancy Induced Hypertension (PIH)	Multiple Gestation ☐ Yes ☐ No				Hepatitis Treated: ☐ Yes ☐ No	☐	☐
☐ Premature ROM	Periodontal Disease	☐	☐	☐	Thalassemia ☐ Alpha ☐ Beta	☐	☐
☐ Premature Labor/Delivery < 32 wks	Poor Weight Gain	☐	☐	☐	HIV	☐	☐
☐ Preterm Labor/Delivery 32-36 wks	IUGR	☐	☐	☐	Renal Disease:	☐	☐
☐ Fetal Demise/Hx 2nd/3rd Tri Loss	PIH	☐	☐	☐	Seizure Disorder	☐	☐
☐ Previous C-Section #	Preterm Dilation of Cervix/Preterm Labor	☐	☐	☐	Sickle Cell Disease: ☐ Trait ☐ Disease	☐	☐
Classical Incision: ☐ Yes ☐ No	Previous delivery w/in 1 yr of EDC	☐	☐	☐	Depression:	☐	☐
Prenatal Visits	Social, Economic, Lifestyle	1st	2nd	3rd	Eating Disorder:	☐	☐
	☐ No Social, Economic, Lifestyle				Bipolar:	☐	☐
	Mental/Physical/Sexual Abuse Hx ☐	☐	☐	☐	Schizophrenia:	☐	☐
	Housing Insecurity	☐	☐	☐	STI:	☐	☐
	Food Insecurity	☐	☐	☐	Thyroid: Treated: ☐ Yes ☐ No	☐	☐
	Special Needs/Challenges	☐	☐	☐	Other Conditions:		
	Substance Use Disorder ETOH Hx ☐	☐	☐	☐			
	Opioid Hx ☐	☐	☐	☐	Delivery: Date at Wks Gestation Elect. Del. ☐ Yes ☐ No		
	Marijuana/THC Hx ☐	☐	☐	☐	☐ VBAC ☐ Vag ☐ C/S Birth Weight:		
	Other Hx ☐	☐	☐	☐	NICU Admit ☐ Yes ☐ No Viable ☐ Yes ☐ No Antenatal Steroids ☐ Yes ☐ No		
	Specify Other:				Postpartum Visit (Between 1-84 days after delivery)		
	Opioid Therapy:	☐	☐	☐	Visit Date: Visit Type? List:		
	Substance Use Screen? ☐ Yes ☐ No				Feeding Method: ☐ Breast ☐ Bottle ☐ Both Contraceptive Plan:		
	Validated Substance Tool Used? List:				PP Depression Present? ☐ Yes ☐ No / Validated Depression Tool Used? List: / Score:		
	Date Admin. Score:				Date Admin. Referral: ☐ Yes ☐ No Follow-Up Date:		
	Referral: ☐ Yes ☐ No Follow-Up Date:				PP Diabetes Testing (PPDM) ☐ Yes ☐ No		
					Quit Tob. During Preg: ☐ Yes ☐ No Remains Tob. Free: ☐ Yes ☐ No		

Physician Signature

Date Signed

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

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:

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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
New 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 Promise ID (13-digits)	Document provider's individual/group identification # including address locator
Initial Submission Date	Document date accordingly
28-32 Week Submit Date	Document date accordingly
Postpartum (PP) Submit 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)
MAID#	Document Medical Assistance ID#
Member Health Plan	Document whether Member belongs to Aetna Better Health, AmeriHealth Caritas Pennsylvania, AmeriHealth Caritas Northeast, Fee for Service, Gateway HealthSM, 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
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
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.
Score	Document Member's depression screening score
Date Admin.	Document date of depression screening
Referral	Document whether Member was referred for treatment for Depression
Follow-Up Date	Document the referral follow-up date
Dental Visit, last 6 months	Document whether Member had a dental visit in the last 6 months
Tubal Desired	Document whether Member desires tubal ligation
Consent Signed	Document whether Member signed a consent form for tubal ligation
Influenza Vaccine Date	Document date of Member's Influenza Vaccination. Use box for N/A and Refused when appropriate.
Tdap Vaccine Date and Gestation	Document date of Member's Tdap vaccination and the gestation week (optional) at the time of vaccination. Use box for N/A and Refused when appropriate.

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, STI, 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. Screen for substance use, if yes whether a validated substance screening tool was used, list the name of tool (4Ps, 4Ps Plus, 5Ps, NIDA Quick Screen, Substance Use Risk Profile Pregnancy (SURP-P) Scale, ASSIST, TICS), date administered, the substance use screening score, and was referral made, referral follow-up date.
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
Elective Delivery	Refers to deliveries performed for low-risk pregnancies due to the woman's or provider's choice, not for medical reasons at ≥ 37 weeks and < 39 weeks of gestation completed.
Postpartum Visit	Document the date of the visit, list the visit type via telehealth (phone or conferencing) or home health visits, screen for postpartum depression, if yes whether a validated depression tool was used, list the name of tool and date administered, the depression screening score, and was referral made, referral follow-up date, and feeding method, whether contraception discussed and plan, postpartum diabetes testing, 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
Commonwealth Towers
303 Walnut Street, 9th Floor
Harrisburg, PA 17101
Phone: 1-800-537-8862
Fax: 717-705-8391

AmeriHealth Caritas Northeast - New East Zone
Bright Start Program
8040 Carlson Road, Suite 500
Harrisburg, PA 17112
Phone : 1-888-208-9528
Fax: 1-855-809-9205

Health Partners Of Philadelphia
Baby Partners Program
901 Market Street, Suite 500
Philadelphia, PA 19107
Phone: 215-967-4690
Fax: 215-967-4492

Aetna Better Health
Special Needs Case Management
2000 Market Street, Suite 850
Philadelphia, PA 19103
Phone: 215-282-3521
Fax: 877-683-7354

GatewayHealth℠
MOMMattersProgram®
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222
Phone: 1-800-392-1147
Fax: 1-888-225-2360

Keystone First Health Plan
Bright Start Program
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-800-521-6867
Fax: 1-877-353-6913

Geisinger Health Plan Family
RightFrom the Start Program
100 North Academy Avenue
Danville, PA 17822-3220
Phone: 570-271-5108
Fax: 570-214-1583

United Healthcare for Families
Healthy First Steps
2 Allegheny Center, Suite 600
Pittsburgh, PA 15212
Phone: 1-800-599-5985
Fax: 1-877-353-6913

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

UPMC Health Plan
Maternity Program
U.S. Steel Tower 37th Floor
600 Grant Street
Pittsburgh, PA 15219
Phone: 1-866-778-6073
Fax: 412-454-8558