



Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call Delaware First Health at 1-877-236-1341 (TTY: 711). This form is also available online at DelawareFirstHealth.com



*Medicaid ID #:

Your First Name:

Your Last Name:

*Your Birth Date MMDDYYYY:

Gender Identification: Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share
 American Indian/Native American Asian Native Hawaiian or Other Pacific Islander
 Hispanic or Latino Other If other ethnicity, please specify:

What Provider/Clinic is helping me during my pregnancy:

First Name:

Last Name:

Phone Number:

Clinic Name (if applicable):

My Current Situation

Please check this box if you would answer no to any of the below:

- I have a phone.
- I feel good about where I live.
- I feel safe at home and with the people in my life.
- I have transportation for my daily needs.
- I have enough food for me and my family each day.
- I am able to pay my utility bills (gas, water, electric, etc).

My Current Pregnancy Information

I have been to my first prenatal visit? Yes No

If yes, how many weeks pregnant were you at your first visit:

*Medicaid ID #:

Name: Last, First:

My due date is (If you do not know your due date, when was the first day of your last period):

This is my first pregnancy Yes No

Where will I give birth to my baby
(Hospital or birthing center):

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Multiples (twins, triplets) | <input type="checkbox"/> High blood pressure or heart problems |
| <input type="checkbox"/> Diabetes (high blood sugar; type I, type II, during pregnancy only) | <input type="checkbox"/> Very bad nausea and vomiting |
| <input type="checkbox"/> Asthma or other breathing problems | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Tobacco use (smoking cigarettes, chewing tobacco, or vaping) | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Depression (feeling blue) | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Anxiety (feeling worried or stressed) | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> I do not have any of these | <input type="checkbox"/> Substance use (fentanyl, opiates, heroin, crack, cocaine, alcohol, marijuana, methamphetamines) |
| <input type="checkbox"/> Other health needs | |

Please explain

My Past Pregnancy History

Please check all that apply:

- Previous delivery before 37 weeks
- Gestational diabetes (high blood sugar while pregnant)
- High blood pressure in pregnancy/preeclampsia or heart problems
- Delivery less than 18 months ago
- Taking any form of progesterone
- Previous C-section
- I did not have any of these or this is my first pregnancy
- Other

Please explain

