



Maryland

DEPARTMENT OF HEALTH

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) Yes No Primary Language _____

Insurance Status (at time of prenatal visit):

Uninsured: Y <input type="checkbox"/> N <input type="checkbox"/>	FFS: Y <input type="checkbox"/> N <input type="checkbox"/>	Applied for Maryland MA: Y ____ N ____ Date: ____/____/____
Maryland Medicaid: Y <input type="checkbox"/> N <input type="checkbox"/>		MCO: _____

Demographics:

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

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 OBCare	____/____/____	LMP ____/____/____	EDC ____/____/____

Risk Factor Assessment:

Psychosocial Risks (Check all that apply)

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

Medical Risks (Check all that apply)

Maternal Age	Age < or = 16 <input type="checkbox"/> Age > or = 35 <input type="checkbox"/>
Maternal BMI	BMI < 18.5 <input type="checkbox"/> or BMI > 30 <input type="checkbox"/>
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 <input type="checkbox"/> N <input type="checkbox"/> Past STI Hx: (Syphilis) <input type="checkbox"/> (Herpes) <input type="checkbox"/>
Chronic Disease	Asthma: Y <input type="checkbox"/> N <input type="checkbox"/> Inhaler Rx: Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes: Y <input type="checkbox"/> N <input type="checkbox"/> If yes then Treatment Medication: _____ Chronic HTN/Heart Disease: Y <input type="checkbox"/> N <input type="checkbox"/> Sickle Cell Disease: Y <input type="checkbox"/> N <input type="checkbox"/> Sickle Cell Trait: Y <input type="checkbox"/> N <input type="checkbox"/> Anemia - HCT < 33 or HGB < 11: Y <input type="checkbox"/> N <input type="checkbox"/> Lab Result _____ Autoimmune Disorder: Y <input type="checkbox"/> N <input type="checkbox"/> If yes please name: _____ H/O - Thrombophilias/DVT: Y <input type="checkbox"/> N <input type="checkbox"/> If yes please describe: _____

Dental Care	Last Dental visit >1 year: Y <input type="checkbox"/> N <input type="checkbox"/>
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Pregnancy Risk Factors (Check all that apply)

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

¹ Mental/Behavioral Health	Concern for the need of BH Services.
¹ Intimate Partner/Family Violence/Abuse	Physical, psychological abuse or violence within the patient's environment.
¹ Exposure to long-term stress	Partner-related, financial, personal, emotional.
² Substance Misuse	<ul style="list-style-type: none"> Concern for use of illegal substances within the past 6 months. At "risk-drinker" as determined by a screening tool such as T-ACE, CAGE, or AUDIT.
³ Financial Insecurity	Example: Unemployed > 3months. Involved in exchanging sex for drugs.
⁴ 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.

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 rd 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	301-334-7740 Fax: 301-334-7746
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
Howard County ACCU 8930 Stanford Blvd. Columbia, MD 21045	410-313-7323 Fax: 410-313-5838

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. **The NPI number if required for payment.**
- 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.

Prior to administering the assessment, please read the following statement to the patient:

“Information from this assessment may be shared with your local health department to help connect you to services. This could include WIC, SNAP and home visiting services, as well as other programs.”

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
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: 240-777-1604
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	443-523-1700 Fax: 410-651-2572
Talbot County ACCU 100S. 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