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_____N_____	FFS: Y ____N _____	Applied for Maryland MA: Y_____N____ Date: ____/____/____
Maryland Medicaid: Y _____N____		MCO: _____

Demographics:

Biologic Sex	Male _____Female_____	Other: _____	
Gender Identity	Cisgender: Male _____Female_____	Other: (Patient's own definition) _____	
Race (check all that apply)	Black or African American _____	Asian _____	American Native _____
	Hispanic _____	Native Hawaiian/Pacific Islander _____	Alaska Native _____
	Non Hispanic White_____	Multiracial_____	Unknown_____
Educational Level:	Highest Grade Completed _____	Currently in School: Yes _____ No_____	GED: Yes ____No____
Marital Status:	Married _____	Unmarried _____	Unknown _____
	Separated _____	Divorced _____	

Obstetric History Gravida_____Para _____:

#Full Term Births		#Preterm Births		#Ectopic Pregnancies	
#Spontanous Abortions		#Theraputic 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[1]	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[2]	Recent Psychiatric Inpatient Admission within <1 year: Y____N____ Admission Diagnosis: _____
Substance Misuse[2]	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[3]	Currently Unemployed:. Y___N_____ Temporary Assistance for Needy Families (TANF) eligibility: Y___N _____
Social Support/Network[4]	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: Y__ N__ If yes please describe: _____
Dental Care	Last Dental visit >1 year. Y_____N_____

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: _____

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	• 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., 3rd 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
Garret County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7770 Fax: 301-334-7771
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

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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.

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 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