Ohio Department of Medicaid

PERINATAL RISK ASSESSMENT

**Required*

*Date of Visit/Service When Completion of This Assessment Form Began *(mm/dd/yyyy)*		
Individual	Practice	Rendering Provider
*Medicaid ID Number *(12 digits)*	*Medicaid ID Number	*Medicaid ID Number
*Social Security Number *(9 digits)*	*NPI	*NPI
*Date of Birth *(mm/dd/yyyy)*		
*Family *(Last)* Name	*Practice Name	Full Name
*Given *(First)* Name / Initial	Address	
Address / Apt.	Address *(if needed)*	
City	City	
State / ZIP Code	State / ZIP Code	
County		
Primary Language *(if not English)*		
E-Mail Address	E-Mail Address	E-Mail Address
Primary Phone Number Text Messages ☐ Yes ☐ No	Phone Number Text Messages ☐ Yes ☐ No	Phone Number Text Messages ☐ Yes ☐ No
Alternate Phone Number Text Messages ☐ Yes ☐ No	Fax Number	
	Name of Person to Whom Questions About This Form Should Be Directed	

*Estimated Due Date *(mm/dd/yyyy)*	*Number of Gestational Weeks	*Number of Gestational Days
*Date on Which Gestational Age Was Recorded *(mm/dd/yyyy)*	*Number of Fetuses	[Postpartum Only] Date of Delivery *(mm/dd/yyyy)*
Permission Given by Individual for Medicaid Managed Care Organization to Send Text Messages		☐ Yes ☐ No
Individual Screened for Health-Related Social Needs *(page 3)*		☐ Yes ☐ No

Maternal Behavioral Health Screening

☐ Depression Name of tool used	☐ Anxiety Name of tool used	☐ SUD Name of tool used

Follow-Up Activities

☐ Referral given for BH Services
☐ Co-located care ☐ CBT ☐ SUD/OUD ☐ Prescription written for BH needs

Date of Activity *(mm/dd/yyyy)*	Date on Which Service Was Received *(mm/dd/yyyy)*

Patient Risk Information

☐ Depression ☐ Schizophrenia ☐ Diabetes
☐ Anxiety ☐ Chronic Hypertension ☐ Other Risks/Diagnoses *(Specify)*

	Current Pregnancy/Delivery	Prior Pregnancy
Tobacco/Nicotine Use	☐	☐
Substance Use Disorder (SUD)	☐	☐
Alcohol Abuse	☐	☐
Opioid Use Disorder (OUD)	☐	☐
Postpartum Depression	☐	☐
Late Start of Prenatal Care	☐	☐
Gestational Hypertension	☐	☐
Preeclampsia	☐	☐
Gestational Diabetes	☐	☐
Low Birth Weight	☐	☐
Preterm Birth	☐	☐

☐ Alcohol Counseling/Treatment
- ☐ Interested in and referred to counseling for alcohol use
- ☐ Currently receiving counseling for alcohol use
- ☐ Declined counseling for alcohol use

☐ Other Substance Abuse Counseling/Treatment
- ☐ Interested in and referred to counseling for other substance use
- ☐ Currently receiving counseling for other substance use
- ☐ Declined counseling for other substance use

☐ Opiate Use
- ☐ Interested in and referred to opioid use treatment *(e.g., methadone, buprenorphine)*
- ☐ Currently receiving opioid use treatment
- ☐ Declined opioid use treatment

☐ Tobacco/Nicotine Counseling/Treatment
- ☐ Interested in and referred to tobacco/nicotine cessation services
- ☐ Interested in quitting or decreasing tobacco/nicotine usage
- ☐ Recently stopped smoking (within 3 months prior to pregnancy)
- ☐ Currently receiving tobacco cessation services
- ☐ Declined tobacco cessation resources

☐ I would like my patient's managed care organization to communicate with my office regarding any urgent needs.

Health-Related Social Needs

Services	Assistance Requested From the Medicaid MCO in Addressing This Need	Communication Requested From the Medicaid MCO About Assistance to Be Provided	Name, E-Mail Address, and Phone Number of the Person with Whom the MCO Should Follow Up
☐ Transportation	☐	☐	
☐ Food	☐	☐	
☐ Housing	☐	☐	
☐ Utilities	☐	☐	
☐ Safety	☐	☐	
☐ Other *(Specify)*	☐	☐	

Referrals

☐ Connection to tobacco cessation services	☐	☐	
☐ Assistance with finding a BH provider	☐	☐	
☐ Assistance with finding a primary care provider	☐	☐	
☐ Connection to SUD services	☐	☐	
☐ WIC	☐	☐	
☐ Home visiting services ☐ Permission is given for text messages about home visiting to be sent to the phone number listed on page 1.	☐	☐	