OB REGISTRATION FORM

Complete and return this form for all obstetrical patients assigned to VPHP, Inc. Information is used by care management teams to educate members and coordinate care. ***Please Fax This Form Back To VPHP, Inc. @ (800) 827-7192***

Patient Information				
Member's Name:		Age:	Date of Birth:	
Current Address:			VPHP ID#	
Patient's Phone Numbers: (Home) (Cell) Alternate Phone Number:			Today's Date :	

Provider Information				
Name of Facility:	Name of Obstetrician:	NPI Number:	Phone Number:	Fax Number:

Patient History				
Current Weight:	Pre-Pregnancy Weight	Height:	Last Menstrual Period:	Sonogram Performed:
Date Prenatal Care Initiated:		Gravida: Live Births:	Para: Ectopic:	EDC:

Risk Assessment

☐ Planned C-Section
Indication:_____
Smoker
Substance Abuse
If yes, list:_____
HIV/AIDS
STD
IF yes, list:_____
IUGR
Incompetent Cervix
Other:_____
Do you consider this a High Risk Pregnancy?
If yes, explain:_____

Additional Comments:
_____
_____
_____
_____
_____

Previous Adverse Pregnancy Outcomes

☐ Premature Births
☐ Stillbirths
☐ Fetal Death
☐ Fetal Abnormalities
☐ Fetal Complications
☐ Abortion
☐ Other:
_____

Current Pregnancy Complications

Maternal Bleeding
Preeclampsia
Diabetes
Hypertension
Nutritional Deficit
Other:_____

Virginia Premier Health Plan, Inc

Contact us:
P.O. Box 5307 Richmond, VA 23220-
Fax to Medical Management: 1-800-827-7192
For Medical Management questions call toll free:
1-888-251-3063
All other questions call toll free: 1-800-727-7536