

Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call CalViva Health toll-free at 1-888-893-1569 (TTY/TTD: 711) 24 hours a day, 7 days a week. This form is also available online at www.calvivahealth.org.

***Medi-Cal 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: _____

*Medi-Cal 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, methphetamines)
<input type="checkbox"/> Other health needs	

Please explain _____

My Past Pregnancy History

Please check all that apply:

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

Please explain _____