

Ohio Department of Medicaid
PRENATAL RISK NOTIFICATION

Patient Name		Recipient Number	
Recipient Name <i>(If different than patient name)</i>			
Patient Address		City	State
Patient Telephone		Expected Delivery Date <i>(MM/DD/YY)</i>	
Patient Enrolled in Managed Care Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		MCP Name	
Provider Name		Provider Telephone	

Does the patient need transportation to medical services? Yes No

Does the patient need WIC services? Yes No

Does the patient need Help Me Grow services? Yes No

Does the patient need other support services?

 Clothing Yes No

 Housing Yes No

 Other Yes No *(Please Specify)* _____

I certify that, on the basis of my professional judgment this patient is at risk of preterm birth or a poor pregnancy outcome. I believe that this patient could benefit from assistance and support services from county department of job and family services.

Additional Comments	
Provider Name	
Provider Signature	Date