







Prenatal and Postpartum Care

Please fax completed forms to 833-667-1532 or send to our secure email MIHEDIS@mhplan.com and			
save a copy in the patient's medical record.			
Patient Name:	DOB:	ID#:	
Date Vitals Collected:/ Blood Pressure:/ Weight: lbs. BMI:			
EDC or EDD:	DD: LMP:		
Prenatal Visit	Type of Service(s) Performed		
Date	Type of Service(s) Performed		
1.	☐ Pregnancy diagnosis	☐ OB Panel	
	☐ Fetal heart tones	\square Prenatal risk assessment and	
	☐ Cervical exam	counseling/education	
	☐ Fundal height	☐ Complete obstetrical history	
	☐ Ultrasound		
	☐ Pregnancy diagnosis	☐ OB Panel	
2.	☐ Fetal heart tones	\square Prenatal risk assessment and	
	☐ Cervical exam	counseling/education	
	☐ Fundal height	☐ Complete obstetrical history	
	☐ Ultrasound		
Postpartum Visit			
Date (occurring			
between seven	Type of Service(s) Performed		
and 84 days			
after delivery)			
1.	☐ Pelvic exam	☐ Glucose screening (for women	
	☐ Evaluation of weight, blood pressure,	with gestational diabetes)	
	breasts, and abdomen	☐ Review of infant care or	
	☐ Perineal/cesarean incision/wound	breastfeeding	
	check	☐ Discussion regarding resumption	
	☐ Screening for depression, anxiety, tobacco use, substance use, or preexisting	of intercourse, birth spacing, or family planning	
	mental health disorders	☐ Discussion regarding sleep/fatigue	
	mental fleatiff disorders	Discussion regarding sleep/ratigue	

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	 Discussion regarding resumption of physical activity and attainment of healthy weight
Provider Name and Credentials (Print):	
Provider Signature:	Date:/
If the form is filled out by an office or clinical s for follow-up and signoff.	support staff member, it must route back to the provider

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