KTF HEALTHY BEGINNINGS PROGRAM

Members must enroll during the first trimester (14 weeks) or within 60-days of initial coverage. Members must remain active and respondent to the program throughout the pregnancy to remain enrolled. Normal office visits and hospital copays apply if patient does not timely enroll in the Healthy Beginnings Program. When you have completed this form, please contact the KTF Pre-Cert Department at 844-583-3863x3.

Date: _____ Physician: _____ Hospital: _____

Name: _____	Insured Name: _____
Address: _____	Address: _____
_____	_____
Date of Birth: _____	Date of Birth: _____
Phone #: _____	Phone #: _____
Work Phone #: _____	Work Phone #: _____

PRENATAL ASSESSMENT

1. Is this your first pregnancy? ☐ Yes ☐ No If no, number of previous pregnancies: _____
   Deliveries: ____ Miscarriages: ____ (Trimester: 1st___ 2nd ____ 3rd _____)
   Abortions: _____ Tubal Pregnancy: _____
2. Number of living children _____ Age of youngest child _____
3. What gestation (weeks) did you deliver previous pregnancies? _____
4. Did any of your babies weigh less than 5 ½ pounds? ☐ Yes ☐ No ☐ Weight: _____
5. Have you had any cesarean sections in the past? ☐ Yes ☐ No
   If so, dates: _____
6. Have you ever had an emergency delivery due to a placental abruption? ☐ Yes ☐ No
7. Have you ever had gestational diabetes? ☐ Yes ☐ No
8. Have you ever had toxemia? ☐ Yes ☐ No

MEDICAL HISTORY

1. Have you ever been told you have, or are you currently under treatment for?

	Yes	No		Yes	No
High blood pressure	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Seizure Disorder	☐	☐
If yes, insulin dependent?	☐	☐	Lupus	☐	☐
Heart disease	☐	☐	Sickle Cell Disease	☐	☐
Tested positive for HIV?	☐	☐	Multiple Sclerosis	☐	☐
Sexually transmitted disease	☐	☐	Ulcerative Colitis	☐	☐
Uterine fibroids	☐	☐	Crohn's Disease	☐	☐
Cervical surgeries	☐	☐	Kidney problems	☐	☐

2. Have you had a Pap smear within the past 12 months? ☐ Yes ☐ No Results? _____
3. Are you currently taking any medications (including herbal supplements)? ☐ Yes ☐ No
   Meds/Supplements: _____
4. Do you have any allergies? ☐ Yes ☐ No

CURRENT PREGNANCY

1. What date have you been told is your due date? _____
2. Have you had an ultrasound? ☐ Yes ☐ No
3. Have you been told you are expecting more than one baby? ☐ Yes ☐ No
4. Did the doctor tell you your amniotic fluid level was unusually low or high? ☐ Yes ☐ No
5. Have you been told you have a placenta previa? ☐ Yes ☐ No
6. Have you been told your blood pressure has been above normal on at least two separate occasions during this pregnancy? ☐ Yes ☐ No
7. Have you had any kidney infection during this pregnancy? ☐ Yes ☐ No
8. Has the doctor told you that you have protein in your urine? ☐ Yes ☐ No
9. Have you had a low blood count (anemia) during this pregnancy? ☐ Yes ☐ No
10. Have you had any bleeding (more than spotting) during your first trimester? ☐ Yes ☐ No
11. During this pregnancy, have you been told you have an elevated CMV titer? ☐ Yes ☐ No
12. Have you been treated for a venereal disease since you have been pregnant? ☐ Yes ☐ No
13. How much do you weigh presently? _____ Before this pregnancy? _____
14. Have you been placed on any activity restrictions by the doctor? ☐ Yes ☐ No
    If yes, explain _____
15. Do you plan to attend childbirth class? ☐ Yes ☐ No

Answer next 3 questions if beyond 1st trimester:

1. If you are between 20-34 weeks gestation, has the doctor told you the cervix is dilated or effaced? ☐ Yes ☐ No
2. Have you experienced preterm labor with this pregnancy? ☐ Yes ☐ No
3. If you are less than 34 weeks, have you had cramps or contractions on a regular basis or been told you have an irritable uterus? ☐ Yes ☐ No

DEMOGRAPHICS

1. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
2. What is your highest level of education? ☐ 8th grade or less ☐ Grade 9-12 ☐ 12+

HOME SITUATION

1. Are you currently caring for any children at home? ☐ Yes ☐ No
2. Is there a high amount of stress at home? ☐ Yes ☐ No
3. Are you fearful of being harmed by anyone at home? ☐ Yes ☐ No

HEALTH HABITS

1. Do you currently smoke? ☐ Yes ☐ No
   If yes, how much? ☐ Less than ½ pack/day ☐ ½ -1 pack/day ☐ 1 ½ -2 packs/day
2. Prior to becoming pregnant, did you use any recreational drugs such as cocaine, LSD, or marijuana? ☐ Yes ☐ No
3. Since you became pregnant have you used any of those drugs? ☐ Yes ☐ No
4. Prior to becoming pregnant, how many alcoholic drinks did you have in a week (average)?
   ☐ None ☐ 6 or less ☐ More than 6 a week
5. Since becoming pregnant, how many alcoholic drinks do you have in a week?
   ☐ None ☐ 6 or less ☐ More than 6 a week
6. Do you eat three meals a day?
   ☐ Almost always ☐ Usually ☐ Occasionally ☐ Never
7. How often do you eat foods that are high in sugar content or add sugar to the foods that you eat or drink?
   ☐ Several times a day ☐ Once a day ☐ Several times a week ☐ Seldom
8. How often do you eat fruits, vegetables, whole grain cereals/breads and other fiber foods?
   ☐ Almost every meal ☐ 1-2 meals a day ☐ 3-4 meals a week ☐ Less than twice a week
9. Do you drink more than five beverages containing caffeine in a day? ☐ Yes ☐ No
10. How many servings of dairy products do you have each day (milk, cheese, etc.)?
    ☐ One or less ☐ 2-4 servings ☐ More than 4 servings
11. Are you currently taking your prenatal vitamins? ☐ Yes ☐ No

WORK ENVIRONMENT

1. Currently how would you describe the amount of stress at work?
   ☐ Mild ☐ Moderate ☐ High
2. Do you have a job that requires heavy physical work, such as lifting or standing in one position?
   ☐ Yes ☐ No
3. Describe the physical work: _____

REMINDER: Enroll the baby within 30 days of the delivery!

Please contact the Compliance Office at 844-583-3863x5 prior to placing your Breast Pump order. You may experience issues with your shipment if you do not.