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OB-GYN Verification of Prenatal Appointment for Medi-Cal Members

Please complete this form to receive your \$100 incentive. Fax a copy to HPSM at (650) 829-2009.

Patient Name: _____

HPSM Member ID #: _____ DOB: _____

This patient was seen on _____ for a prenatal appointment. Because her
(Date)
EDD is _____, this appointment falls within her first trimester.
(Date)

Please check off the procedures performed at this visit:

Documentation of LMP or EDD in conjunction with either:

- Prenatal risk assessment** and counseling/education
- Complete **obstetrical history**

A basic **physical OB exam** that includes:

- Auscultation** for fetal heart tone
- Pelvic exam** with obstetric observations
- Measurement of **fundus height**
- Screening test in the form of an **obstetric panel** (e.g., hematocrit, differential WBC, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing)
- TORCH antibody panel** alone or with a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing
- Echography** of a pregnant uterus

By signing below, I verify that the information above is true and accurate.

MD Signature

Date

MD Name (Print/ stamp)