Induction of Labor Prior to 39 Weeks and Scheduled Elective C-Sections

Upload this request through the Provider Web Portal.

For questions regarding this form, call: (800) 525-2395

Purpose: A hospital will use this form to request authorization for an induction of labor before 39 weeks or a scheduled elective Cesarean Section (C-Sect.).

DATE OF REQUEST: _____/_____/_____

REQUEST TYPE: ☐ **Induction of Labor** ☐ **Cesarean Section**

NOTES:

RECIPIENT INFORMATION		
Recipient Name (Last, First, MI):		
Recipient ID:		DOB:
Address:		Phone:
City:	State:	Zip Code:
Guardian Name (*if applicable*):		Guardian Phone:
Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:		
Other Insurance Name:	Other Insurance ID#:	

ORDERING PROVIDER INFORMATION		
Ordering Provider Name:		NPI:
Address:		Contact Name:
City:	State:	Zip Code:
Phone:		Fax:

SERVICING PROVIDER INFORMATION *(facility)*		
Facility Name:		NPI:
Facility Address:		Contact Name:
City:	State:	Zip Code:
Phone:		Fax:

CLINICAL INFORMATION		
Estimated Admission Date:	Estimated Length of Stay: _____ days	Estimated Discharge Date:

Admission Diagnosis	**Description**
1.	
2.	
3.	

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Revenue Code	Description
1.	
2.	
3.	
Requested Procedures	**Description**
1.	
2.	
3.	
Other Requested Services	**Description**
1.	
2.	
3.	

Please provide appropriate clinical information to support your request

EDC:	Gestational age at date of induction or C/S (week+day):

EDC based on:

☐ US 10-20 weeks ☐ Doppler FHT+ for 30 weeks ☐ +hCG for 36 weeks

☐ Other dating criteria (by ACOG Guidelines, women should be 39 weeks or greater before initiating an elective (no indication) delivery. ACSG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery):

☐ Fetal Lung Maturity test result:	Date:

Early Induction of Labor Indications: *(check all that apply)*

Obstetric and Medical Conditions:

☐ Chronic HTN	☐ Coag/Thrombophilia	☐ Diabetes (Type I or II)	☐ Fetal Demise (current)
☐ Fetal Demise (prior)	☐ Fetal Malformation	☐ GDM with insulin	☐ Gestational HTN
☐ Heart Disease	☐ HIV	☐ Isoimmunization	☐ IUGR
☐ Liver Disease (e.g., cholestasis of pregnancy)	☐ Oligohydramnios	☐ Polyhydramnios	☐ Preeclampsia
☐ Previa	☐ PROM	☐ Pulmonary Disease	☐ Renal Disease
☐ Twin with complication	☐ Other:		

If "Other" chosen, then enter name of perinatology consult who agrees with plan:

Scheduled Cesarean Section (≥ 39 weeks) Indications:

☐ Breech Presentation	☐ Other Malpresentation	☐ Patient Choice

☐ Prior C/S	☐ Prior classical C/S	☐ Prior Myomectomy (may be earlier with fetal lung maturity test)	☐ Twin w/o complication (OK ≥ 38 weeks)

☐ Other:

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Elective Induction (≥ 39 weeks) Indications:		
☐ Distance *(please specify):*		
☐ Macrosomia	☐ Patient Choice/Social	☐ Other
If "Other" chosen, please specify:		
Indication's description/details:		
Severity of Illness (signs and symptoms, abnormal lab or other test findings):		
Intensity of Service (plan of treatment including diagnostic and other services):		
Discharge Plan:		

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