Babyline

**Helpline operator**

**Please record, but DO NOT display:**

**Date of Call (When the information is entered on the form. Date and time.)**

**Client ID number (Please have the ID number start with 001 and correspond with the number of callers. For example, the 16th person to call this number will be given ID 016)**

*What is your full name? Please include your first, middle and last names.*

**Consumer First Name**

**Middle Name**

**Last Name**

*What is your date of birth?*

**Date of Birth**

**\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

**mm dd yyyy**

*How old are you?*

**Age (in years)**

*What race would you say you are?*

**Race**

-White/Caucasian

- Black/African-American

-Asian

-Native American

-Mixed race

-Other

*Are you Hispanic?*

***Ethnicity***

-Yes

-No

*What is the address for where you live?*

**Street Address**

**City**

**Zipcode**

*What is the best phone number to reach you?*

**Phone Number**

*Is it OK to leave a message for you at this number?*

**Message Ok?**

-Yes

-No

*Is there another number you would like us to call if we cannot reach you at the other number you provided?*

**Phone Number (if applicable)**

*What is your marital status? Are you…*

**Marital Status**

-Single

-Married

-Living as married

-Divorced or separated

-Widowed

*What is the highest grade you have completed in school?*

**Education**

-Some high school

-High school graduate

-Technical/trade school

- Some college

- College graduate

*Are you still in school?*

If yes:

**Current school**

*Are you currently employed?*

**Employment**

-Yes

-No

*How many people currently live in your household?*

**# in Household**

*What is your yearly income?*

**Income**

-Less than $20,000

- $20,000-$50,000

-More than $50,000

*Do you have health insurance?* If yes, *what kind of insurance?*

**Insurance**

-None

-Government subsidized (Eg. SoonerCare)

-Private insurance (personal pay or through employer)

*Where did you take your pregnancy test?*

**Pregnancy Test Location**

-Home pregnancy test

-Pregnancy test at a healthcare clinic

*Were you trying to get pregnant?*

**Pregnancy attempted?**

-Yes

-No

*Were you using birth control method at the time you got pregnant?*

**Birth Control**

-Yes

-No

IF YES,

1.) *What type of birth control were you using?*

- Condoms

- Birth control pills (Oral contraceptives)

- Nuva Ring

- Depo-Provera (Injectable contraceptive)

- IUD (Copper or Mirena/Skyla)

- Implant (Implanon)

*What was the first day of your last menstrual period?*

**LMP**

**\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ (Calendar)**

**mm dd yyyy**

**Estimated due date**

**\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ (Calendar)**

**mm dd yyyy**

Auto populate by adding 280 calendar days to the LMP.

**Approximate gestation (weeks)**

Auto populate by calculating time (in weeks) from LMP to current date.

*How many times have you been pregnant in the past?*

**Past pregnancies**

If 1 or more past pregnancies are reported,

*How many were live births?*

**Live births**

*\*\*\*How many were stillbirths?*

**Stillbirths**

*\*\*\*How many were miscarriages?*

**Miscarriages**

*\*\*\*How many were abortions?*

**Abortions**

*\*\*\*How many were tubal pregnancies?*

**Tubal Pregnancies**

*\*\*\*Have you had any previous C-sections?*

**C-sections**

-Yes

-No

*What was the date of your last birth (*If any live or stillbirths were reported)?

**Date of last birth**

**\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

**mm dd yyyy**

*Are you currently experiencing any of the following symptoms?*

**\*\*\*Pain or Fever**

-Yes

-No

**\*\*\*Abnormal Bleeding**

-Yes

-No

**\*\*\*Unusual Discharge**

-Yes

-No

**\*\*\*Headache**

-Yes

-No

**\*\*\*Severe vomiting**

-Yes

-No

**\*\*\*UTI**

-Yes

-No

**\*\*\*Swelling**

-Yes

-No

**\*\*\*Cramping**

-Yes

-No

**\*\*\****In the past year, have you been hit, punched, kicked, or otherwise hurt by someone?*

**Safety I**

-Yes

-No

**\*\*\*** *Do you feel unsafe in your current relationship?*

**Safety II**

-Yes

-No

**\*\*\****Is there a partner from a previous relationship who is making you feel unsafe now?*

**Safety III**

-Yes

-No

*Do you have a history of any of the following health conditions?*

**\*\*\*Diabetes**

-Yes

-No

**\*\*\*Heart/Lung Disease**

-Yes

-No

**\*\*\*Seizures**

-Yes

-No

**\*\*\*Thyroid Problems**

-Yes

-No

**\*\*\*High Blood Pressure**

-Yes

-No

*Are you currently taking any prescription medications?*

**\*\*\*Prescription Meds**

-Yes

-No

If yes, *What medications?*

**Medications**

**If any of the questions marked with (\*\*\*) are answered with a “Yes”, identify the client as “High Priority”. Have the High Priority status be displayed at this point.**

*Would you like us to make you an appointment to be seen by a health provider?*

**Appointment?**

-Yes

-No

If yes, schedule appointment.

**Appointment Clinic**

OSU Physicians | Obstetrics and Gynecology

OSU Women’s Health Center

James Goodwin Health Center

Central Regional Health Center

North Regional Health Center

Sand Springs Health Center

Collinsville Community Health Center

Morton Comprehensive Health Services

Planned Parenthood of the Heartland

Community Health Connection

OU Physicians | Women’s Health Care Specialists

OU Physicians | Family Medicine

**Appointment Date**

**\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

**mm dd yyyy**

**Appointment Time**

**\_\_\_\_:\_\_\_\_\_ \_\_\_\_\_\_**

**HH MM am/pm**

*Are you enrolled in any of the following programs?*

**WIC**

-Yes

-No

**Children First**

-Yes

-No

**Healthy Start**

-Yes

-No

*Is there other information you would like us to know?*

**Final Comments**