Republic of the Philippines
Department of Health
CENTER FOR HEALTH DEVELOPMENT
SOCCSKSARGEN Region

RISK ASSESSMENT CHECK LIST FOR HIGH-RISK PREGNANT WOMEN

A. Personal Data

Date: date_referred

Name of Facility: facility_name	**Address of Facility: facility_address**
Name of Patient: patient_name	**Age/Sex: age / sex**
Address of Patient: patient_address	**Birthday**: birthday
Contact No. of Patient: patient_contact	**Religion**: religion
Philhealth Number: phil_number	**Ethnicity**: ethnicity
Family Monthly Income: Rich(>219,140)☐ High(131,484-219,140)☐ Upper-Middle(76,670-131,483)☐ Middle(43,829-76,669)☐ Lower-Middle(21,915-43,828)☐ Low(10,958-21,914)☐ Poor(< 10,957)☐	**Marital Status:** Single☐ Married☐ Divorced☐ Widowed☐ Legally Separated☐
Educational Attainment: Elementary☐ Highschool☐ College☐	**Sibling Rank:** no out of no

Gravidity: gravidity Parity: partity FTPAL: ftpal LMP: LMP EDC/EDD: EDC_EDD
Height: height Weight: weight BMI: bmi Fundic Height: fund_height BP: bp HR: hr RR: rr Temp.: temp
Td1: td1 Td2: td2 Td3: td3 Td4: td4 Td5: td5

B. Antepartum Conditions (Medical/Obstetrical History) *Place a ☑ if Yes, ☒ if No*

Risk Factors					Remarks/Management
☐Hypertension	☐Anemia	☐Malaria	☐Cancer	☐Allergies	**S**ubjective**:** subjective **O**bjective**:** BP: bp Temp: temp HR: hr RR: rr FH: fh FHT: fht Other Physical Examination: other_phtsical **A**ssessment /Diagnosis**:** assesstment_diagnosis **P**lan/Intervention**:** plan_inter
☐Renal Disease	☐Typhoid disorders	☐Hypo/Hyper thyroidism	☐Tuberculosis	☐Diabetes Mellitus	
☐Hepatitis B infection	☐HIV-AIDs/ STI	☐Seizure Disorder	☐Cardiovascular disease (CHD/IHD)	☐Malnutrition <18.5 BMI	
☐Hematologic/ Bleeding disorders	☐Alcohol/ Substance Abuse	☐Patient w/ anti-phospholipid syndrome	☐Obstructive or restrictive pulmonary disease (Asthma)	☐Patients w/ psychiatric conditions /mental retardation	
☐Habitual abortion (2 consecutive abortions and 3/more repeated abortion)	☐Birth of fetus with congenital anomaly	☐Previous caesarean section	☐Preterm Delivery resulting to still birth or neonatal death	☐ Others: others	

C. Laboratory Results

Date of Lab.	CBC result	UA Result	UTZ	Blood Type	HBsAg Result	VDRL Result	Management/Intervention
date_of_lab	**Hgb**: hgb123 **WBC**: wbc 123 **RBC**: rbc123 **Platelet**: platelet **Hct**: hct123	**Pus: pus123 RBC: rbc 123 Sugar: suger123** **Specific gravity: gravity Albumin: albumin**	Utz1	☐A+ ☐A- ☐B+ ☐B- ☐AB+ ☐AB- ☐O+ ☐O-	☐ **Reactive** ☐ **Non-Reactive**	☐ **Reactive** ☐ **Non-Reactive**	Remarks1
date_of_lab	**Hgb**: hgb123 **WBC**: wbc 123 **RBC**: rbc123 **Platelet**: platelet **Hct**: hct123	**Pus: pus123 RBC: rbc 123 Sugar: suger123** **Specific gravity: gravity Albumin: albumin**	Utz2				Remarks2
date_of_lab	**Hgb**: hgb123 **WBC**: wbc 123 **RBC**: rbc123 **Platelet**: platelet **Hct**: hct123	**Pus: pus123 RBC: rbc 123 Sugar: suger123** **Specific gravity: gravity Albumin: albumin**	Utz3				Remarks3
date_of_lab	**Hgb**: hgb123 **WBC**: wbc 123 **RBC**: rbc123 **Platelet**: platelet **Hct**: hct123	**Pus: pus123 RBC: rbc 123 Sugar: suger123** **Specific gravity: gravity Albumin: albumin**	Utz4				Remarks4
date_of_lab	**Hgb**: hgb123 **WBC**: wbc 123 **RBC**: rbc123 **Platelet**: platelet **Hct**: hct123	**Pus: pus123 RBC: rbc 123 Sugar: suger123** **Specific gravity: gravity Albumin: albumin**	Utz5				Remarks5

D. Warning Signs and Symptoms of Pregnancy. *(Place a ☑ if Yes, ☒ if No)*

RISK FACTORS (a **YES** to **AT LEAST ONE** of the boxes indicates **REFERRAL** to a higher facility)	**1st Trimester (1-12 weeks or 0-84 days)**				
	1st Visit	**2nd Visit**	**3rd Visit**	**4th Visit**	**5th Visit**
	Date: date1	**Date: date2**	**Date: date3**	**Date: date4**	**Date: date5**
	Management	**Remarks**	**Remarks**	**Remarks**	**Remarks**
☐Vaginal spotting or bleeding ☐Severe nausea and vomiting ☐Significant decline fetal movement (less than 10 in 12 hrs during 2 ½ of pregnancy) ☐Persistent contractions ☐Premature rupture of the bag of water/ membrane ☐Multi fetal pregnancy ☐Persistent severe headache, dizziness, or blurring of vision ☐Abdominal pain or epigastric pain ☐Edema of the hands, feet or face ☐Fever or pallor ☐Seizure or loss of consciousness ☐Difficulty of breathing ☐Painful urination ☐Elevated blood pressure (>120/90)	**S**ubjective**:** subjective1 **O**bjective**:** AOG: aog BP: bp Temp: temp HR: hr RR: rr FH: fh FHT: fht Other Physical Examination: other_physical **A**ssessment /Diagnosis**:** Assessment_diag **P**lan/Intervention**:** plant_intervention	**S**ubjective**:** subjective1 **O**bjective**:** AOG: aog BP: bp Temp: temp HR: hr RR: rr FH: fh FHT: fht Other Physical Examination: other_physical **A**ssessment /Diagnosis**:** Assessment_diag **P**lan/Intervention**:** plant_intervention	**S**ubjective**:** subjective1 **O**bjective**:** AOG: aog BP: bp Temp: temp HR: hr RR: rr FH: fh FHT: fht Other Physical Examination: other_physical **A**ssessment /Diagnosis**:** Assessment_diag **P**lan/Intervention**:** plant_intervention	**S**ubjective**:** subjective1 **O**bjective**:** AOG: aog BP: bp Temp: temp HR: hr RR: rr FH: fh FHT: fht Other Physical Examination: other_physical **A**ssessment /Diagnosis**:** Assessment_diag **P**lan/Intervention**:** plant_intervention	**S**ubjective**:** subjective1 **O**bjective**:** AOG: aog BP: bp Temp: temp HR: hr RR: rr FH: fh FHT: fht Other Physical Examination: other_physical **A**ssessment /Diagnosis**:** Assessment_diag **P**lan/Intervention**:** plant_intervention

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ACKNOWLEDGEMENT RECEIPT

(*for immediate return to hospital/clinic of Origin by the accompanying hospital/clinic personnel*)

Date/Time: ____________________________

Name of Patient: ____ **Age**: _______ **Contact No:** __________________________

Address: ____

Referred to (Accepting Facility): ____ **Contact No:** _______________

Status/Condition upon Receipt at ER: ____

Action Taken: Admitted ☐ Referred to other facility ☐ Treated/Managed as OPD ☐

Remarks: ____

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Staff Name and Signature of Receiving Facility