Comprehensive Perinatal Services Program
Prenatal Assessment/Reassessment and Individualized Care Plan

Initial: _____/_____ (Date / Weeks) 2nd Trimester: _____/_____ (14-27 Weeks) (Date / Weeks) 3rd Trimester: _____/_____ (28 Weeks – Delivery) (Date / Weeks)

Client Name: First Last Date of Birth: 01/20/1988

Health Plan: Paperwork Health Plan ID Number: 1548978551785

Provider: Paperwork Health Hospital: Paperwork Demo Hospital

Case Coordinator: Casey Coordination EDD: _____

Dx. OB High Risk Condition: _____ Gravida: _____ Para: _____

Personal Information	**Individualized Care Plan**
1. Client age: □ Less than 12 years □ 12-17 years ☒ 18-34 years □ 35 years or older	Intervention/Referral: □ Reviewed/discussed □ STT FS: *Approaching Clients of Different Ages* □ STT PSY: *Teen Pregnancy and Parenting* □ Child Abuse Report filed (if younger than 18 and abuse suspected)/date: _____ □ Discussed importance of genetic counseling (if over 35) □ Signed up for Text4Baby by texting BABY or (BEBE for Spanish) to 511411 □ Referred to Adolescent Family Life Program/date:_____ □ Referred to home visitation program/date:_____ □ Referred to/date:_____
2. Are you: □ Married □ Single ☒ Living with partner □ Divorced/Separated □ In a relationship □ Widowed □ Other_____	Intervention/Referral: □ Referred to/date:_____
3. How long have you lived at your current home? ☒ Over one year □ Under one year, previously lived:_____ □ Familiar with local area □ Not familiar with local area Place of birth:_____	Intervention/Referral: □ Reviewed/discussed STT FS: □ *Cultural Considerations* □ *Cross Cultural Communication* □ *Client's with Alternative Health Care Experiences* □ STT PSY: *New Immigrant* □ Provided additional orientation about:_____
4. Do you plan to stay in this area for the rest of your pregnancy? ☒ Yes □ No, explain: _____ □ Unsure, explain: _____	Intervention/Referral: □ Provided assistance in transferring her care □ Referred to/date:_____
5. How many years of school have you completed? □ 0-8 years □ 9-11 years ☒ 12-16 years □ 16+ years	Intervention/Referral: □ Referred to school program for pregnant/parenting teens/date:_____ □ Referred to adult school/GED Program/date:_____ □ Referred to English as a Second Language (ESL) Program/date:_____ □ Referred to/date:_____
6. What language do you prefer to speak? ☒ English □ Spanish □ Other: _____ What language do you prefer to read? □ English □ Spanish □ Other: _____	Intervention/Referral: □ Reviewed/discussed STT FS: □ *Cross Cultural Communication* □ *Dealing with Language Barriers* □ *Guidelines for Using Interpreters* □ Provided education in preferred language □ Interpretation services requested from:_____
7. Which of the following bests describes how you read: ☒ Like to read and read often □ Can read, but don't read very often □ Can't read	Intervention/Referral: □ Provided verbal/visual/written information appropriate for client's ability □ Reviewed STT FS: *Low Literacy Skills* □ Referred to Public Library or Adult Literacy Program/date:_____ □ Referred to/date: _____
8. Father of baby: Name: John Doe Language: English Education: High School Age: 31	Intervention/Referral: □ Referred to legal assistance/date:_____ □ Provided information on declaring paternity (per STT PSY: *Teen Pregnancy and Parenting* – even if client is not a teen) □ Reviewed/discussed STT PSY: □ *Child Abuse and Neglect* □ *Legal/Advocacy Concerns* □ Child Abuse Report filed (based on client/partner ages or suspected abuse)/date:_____ □ Referred to/date:_____

9. Is this a planned pregnancy? □ Yes □ No, describe: _____ Is this a wanted pregnancy? □ Yes □ Unsure □ No, describe:_____	Intervention/Referral: □ Reviewed/discussed STT PSY: □ *Unwanted Pregnancy*_____ □ ***Uncertain About Pregnancy?***_____ □ ***Choices***_____ □ Provided information about Safe Surrender program/date:_____ □ Referred to adoption services/date:_____ □ Referred to abortion services/date:_____ □ Referred to provider for/date:_____ □ Referred to social worker/date:_____ □ Referred to/date:_____
10. Are you thinking about abortion or adoption? □ No □ Yes: □ Adoption □ Abortion	
11. How do you feel about being pregnant now? 0-13 Weeks: □ Good □ Unsure □ Troubled Explain: _____ 14-27 Weeks: □ Good □ Unsure □ Troubled Explain: _____ 28-40 Weeks: □ Good □ Unsure □ Troubled Explain: _____	Intervention/Referral: □ Referred to social worker/date:_____ □ Referred to mental health clinic/date: _____ □ Referred to home visitation program/date: _____ □ Reviewed/discussed STT PSY: □ *Financial Concerns* □ *Legal/Advocacy Concerns* □ Referred to/date:_____
12. How does the father of the baby feel about the pregnancy? _____ Your family? _____ Your friends? _____	Intervention/Referral: □ Referred to home visitation program/date:_____ □ Provided information on declaring paternity (per STT PSY: Teen Pregnancy and Parenting – even if client is not a teen) □ Reviewed/discussed STT Psychosocial: *Financial Concerns* and *Legal/Advocacy Concerns* □ Referred to/date: _____

Economic Resources

13. a) Are you currently working or going to school? □ No □ Yes, Type of school/work: _____ Hours per week: _____ b) Do you plan to work or go to school while you are pregnant? □ Yes □ No c) Do you plan to return to work/school after baby is born? □ Yes □ No	Intervention/Referral: □ Referred to school program for pregnant/parenting teens (if under 18 and has not graduated or passed the California High School Proficiency Exam/date: _____ □ Reviewed/discussed STT HE: □ *Workplace Safety*, □ ***Keep Safe at Work*** STT PSY: □ *Financial Concerns*, □ *Legal/Advocacy Concerns* □ Reviewed/discussed pumping/storing breastmilk per STT NUTR: *Breastfeeding* □ Referred to childcare/date:_____ □ Referred to/date:_____
14. Will the father of the baby provide financial support for you and the baby? □ Yes □ No □ Unsure Other sources of financial help:_____	Intervention/Referral: □ Reviewed/discussed STT PSY: *Financial Concerns* for information on the father's requirement to pay child support □ Reviewed/discussed STT PSY: *Legal/Advocacy Concerns* □ Referred to LA County Child Support Services: 1-866- 901-3212/date:_____ □ Referred to/date:_____

15. Are you receiving any of the following?

	0-13 Weeks		14-27 Weeks		28-40 Weeks		Referral & Date
	Yes	No	Yes	No	Yes	No	
WIC	□	□	□	□	□	□	
CalFresh (Food Stamps)	□	□	□	□	□	□	
CalWORKs	□	□	□	□	□	□	
Medi-Cal	□	□	□	□	□	□	
Emergency Food Assistance	□	□	□	□	□	□	
Pregnancy disability benefits	□	□	□	□	□	□	
Other:_____	□	□	□	□	□	□	

16. a) In the past 12 months, have you worried whether your food would run out before you got money to buy more? □ No □ Yes, explain: _____ b) In the past 12 months, did you experience that the food you bought just didn't last and you didn't have money to get more? □ No □ Yes, explain: _____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Getting Healthy Foods* □ ***Tips for Healthy Food Shopping*** □ ***You Can Buy Healthy Food on a Budget*** □ ***You Can Stretch Your Dollars: Choose These Easy Meals and Snacks*** □ Referred to food bank/date:_____ □ Referred to/date:_____

Client Name/ID:

Housing

17. What type of housing do you currently live in?
- □ House
- □ Apartment
- □ Trailer Park
- □ Public Housing
- □ Other:_____
- □ Hotel/Motel
- □ Farm Worker Camp
- □ Emergency Shelter
- □ Car

Any changes in housing?

14-27 Weeks: □ No □ Yes, explain:_____

28-40 Weeks: □ No □ Yes, explain:_____

18. Members of household (not including client):

Number of adults:_____

Relationship to client:_____

Number of children:_____

Relationship to client:_____

19. Was your house or apartment built before 1978?
□ No □ Yes □ Unsure

Is there chipping or peeling paint inside or outside the home?
□ No □ Yes □ Unsure

20. Is your current housing safe and adequate for you and your children)?

0-13 Weeks: □ Yes □ No, explain:_____

14-27 Weeks: □ Yes □ No, explain:_____

28-40 Weeks: □ Yes □ No, explain:_____

Intervention/Referral:
- □ Reviewed/discussed STT PSY: *Financial Concerns*_____
- □ Referred to LA County Housing Resource Center: 1-877-428-8844/date:_____
- □ Referred to emergency housing/homeless shelter/date:_____
- □ Referred to LA County Lead Poisoning Prevention Hotline: 1-800-LA-4-LEAD/date:_____
- □ Referred to/date:_____

21. Do any of your children or your partner's children live with someone else?
- □ N/A
- □ No
- □ Yes, explain:_____

Intervention/Referral:
- □ Reviewed/discussed STT PSY: □ *Parenting Stress* □ *New Immigrant* □ *Legal/Advocacy Concerns*
- □ Referred to National Parent Helpline: 1-855-427-2736/date:_____
- □ Referred to family support/counseling or child abuse prevention program/date:_____
- □ Referred to/date: _____

22. Do you have the following where you live?

	0-13 Wks		14-27 Wks		28-40 Wks	
	Yes	No	Yes	No	Yes	No
Toilet	□	□	□	□	□	□
Stove/place to cook	□	□	□	□	□	□
Tub/shower	□	□	□	□	□	□
Electricity	□	□	□	□	□	□
Refrigerator	□	□	□	□	□	□
Hot/cold water	□	□	□	□	□	□
Phone	□	□	□	□	□	□
Smoke detectors	□	□	□	□	□	□
Windows that open/close	□	□	□	□	□	□

Intervention/Referral:
- □ Reviewed/discussed STT NUTR: □ *Cooking and Food Storage*_____ □ *Food Safety*_____ □ ***When You Cannot Refrigerate: Choose These Foods***_____ □ ***Tips for Cooking and Storing Food***_____ □ ***Don't Get Sick From the Foods You Eat***_____
- □ Referred to LA County Housing Resource Center 1-877-428-8844/date:_____
- □ Referred to HUD 1-213-894-8000/date: _____
- □ Referred to Housing Rights Center 1-800-477-5977/date: _____
- □ Referred to local fire department/date: _____
- □ Referred to social worker/date:_____

23. Do you have a gun in your home?
- □ No
- □ Yes, how is it stored? _____

Intervention/Referral:
- □ Provided information about safe gun storage
- □ Educated client that unwanted guns may be turned in to most local law enforcement agencies/date: _____
- □ Referred to/date:_____

Client Name/ID:

Transportation

24. Will you have any problems coming to your appointments or attending classes due to transportation, childcare, work, school, or another reason? 0-13 Weeks: □ No □ Yes: _____ 14-27 Weeks: □ No □ Yes: _____ 28-40 Weeks: □ No □ Yes: _____	Intervention/Referral: □ Referred to childcare/date:_____ □ Referred to transportation services/date:_____ □ Referred to/date:_____ □ Provided bus tokens or taxi vouchers/date: _____
25. a) When you ride in a car, do you use seatbelts? □ Always □ Sometimes □ Never b) Do you know how to use a seat belt when pregnant? □ Yes □ No	Intervention/Referral: □ Reviewed/discussed STT HE Handout: ***Pregnant? Steps for a Healthy Baby***
26. Do you have a car seat for the new baby? 14-27 Weeks: □ Yes □ No 28-40 Weeks: □ Yes □ No	Intervention/Referral: □ Reviewed/discussed to STT HE: □ *Infant Safety and Health*_____ □ ***Keep Your Baby Safe and Healthy***_____ □ Give referral to free or low-cost car seat program/date:_____ □ Delivery hospital provides car seat prior to discharge
27. How will you get to the hospital? 14-27 Weeks: _____ □ Unsure □ No transportation available 28-40 Weeks: _____ □ Unsure □ No transportation available	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Preterm Labor*_____ □ *Hospital Orientation*_____ □ ***If Your Labor Starts Too Early***_____ □ Assist client in scheduling tour of delivery hospital/date:_____ □ Provided bus tokens or taxi vouchers/date:_____ □ Referred to childcare/date:_____ □ Referred to transportation services/date:_____

Current Health Practices

28. Do you have a primary care doctor for you and your family? □ Yes □ No	Intervention/Referral: □ Reviewed/discussed to STT Appendix: *Introduction to Managed Care* □ Referred to/date:_____
29. Do you have a doctor for your baby? 14-27 Weeks: □ No □ Yes, who?_____ 28-40 Weeks: □ No □ Yes, who?_____	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Infant Safety and Health*_____ □ ***When Your Newborn Baby is Ill***_____ □ ***Your Baby Needs to be Immunized***_____ □ Referred to CHDP provider/date:_____
30. a) Have you been to a dentist in the last 6 months? □ Yes □ No b) Do you have any problems with your teeth, gums or mouth such as toothaches, bleeding gums, or a bad taste or smell? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed STT HE □ *Oral Health During Pregnancy*_____ □ ***Prevent Gum Problems When You Are Pregnant***_____ □ ***See a Dentist When You Are Pregnant***_____ □ ***Keep Your Teeth and Mouth Healthy! Protect Your Baby Too***_____ □ Referred to registered dietitian/date:_____ □ Referred to dentist/date:_____
31. How many total hours do you sleep at night? 0-13 Weeks: ____ 14-27 Weeks: ____ 28-40 Weeks: ____ How many total min/hours do you nap during the day? 0-13 Weeks: ____ 14-27 Weeks: ____ 28-40 Weeks: ____	Intervention/Referral: □ Discuss using extra pillows for joint or back discomfort. To improve relaxation, offer deep breathing, visualization and relaxation techniques/date: _____ □ Reviewed/discussed STT PSY: □ *Emotional or Mental Health Concerns*_____ □ *Depression*_____ □ ***How Bad are Your Blues?*** _____ □ Referred to/date:_____
32. Do you exercise? 0-13 Weeks: □ No □ Yes, type/frequency:_____ 14-27 Weeks: □ No □ Yes, type/frequency:_____ 28-40 Weeks: □ No □ Yes, type/frequency:_____	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Safe Exercise and Lifting*_____ □ ***Exercises To Do When You Are Pregnant***_____ □ ***Stay Active When You Are Pregnant***_____ □ ***Keep Safe When You Exercise***_____ □ Referred to provider for discussion of vigorous exercise (lifting heavy weights, running, etc.) during pregnancy/date:_____ □ Referred to exercise or fitness resources that are low-cost/date:_____ _____

Client Name/ID:

33. Are you currently smoking or using any tobacco products (including hookah or vaping)?

0-13 Weeks:	□ No	□ Yes: How much per day?_____ For how many years?_____ Have you tried to quit? □ Yes □ No
14-27 Weeks:	□ No	□ Yes, how much per day?_____ Have you tried to quit? □ Yes □ No
28-40 Weeks:	□ No	□ Yes, how much per day?_____ Have you tried to quit? □ Yes □ No

34. Are you often around other people who smoke cigarettes or any other tobacco products?
□ Yes □ No

Intervention/Referral:
□ Reviewed/discussed STT HE: □ *Tobacco Use*_____ □ ***You Can Quit Smoking***_____ □ *Secondhand Tobacco Smoke*_____
□ Referred to California Smokers' Helpline for free counseling or information about secondhand smoke: 1-800-NO-BUTTS or 1-800-45-NO-FUME (Spanish)/date:_____
□ Referred to smoking cessation program/date:_____
□ Referred to provider for additional counseling on smoking cessation/date: _____
_____

35. Do you use or have exposure to any of the following at home, work, or doing any hobbies?

	0-13 Weeks	14-27 Weeks	28-40 Weeks
Products like bleach, ammonia or oven cleaners	□	□	□
Pesticides or chemicals	□	□	□
Cooking with clay pottery	□	□	□
Jewelry making	□	□	□
Glue	□	□	□
Fertilizers	□	□	□
Cat litter box	□	□	□
Pet turtles or reptiles	□	□	□
Rodents	□	□	□
Douching	□	□	□
Hot baths or saunas	□	□	□
X-Rays	□	□	□
Other:_____	□	□	□
None	□	□	□

Intervention/Referral:
□ Reviewed/discussed STT HE: □ *Cautions While Pregnant*_____ □ *Workplace Safety*_____ □ ***Pregnant? Steps for a Healthy Baby***_____ □ ***Keep Safe at Work***_____
□ Referred to provider to discuss any harmful exposure to chemicals at home or work/date:_____
□ Referred to MotherToBaby: www.mothertobaby.org or 1-866-626-6847/date: _____

36. At home, where do you store the following?:
Vitamins _____
Medications _____
Cleaning Supplies _____

Are these things kept out of the reach of children?
□ Yes □ No

Intervention/Referral:
□ Reviewed/discussed STT HE Handout: ***Keep Your New Baby Safe***

37. Have either of your parents had a drug or alcohol problem?
□No □Yes, describe:_____

Does your partner have a problem with drugs or alcohol?
□No □Yes, describe:_____

Have you had a problem with drugs or alcohol in the past?
□No □Yes, describe:_____

38. Have you used drugs or alcohol during this pregnancy? Drugs would include things like marijuana, heroin, cocaine, or ecstasy and alcohol would include things like beer, wine, or liquor.

0-13 Weeks: □ No □ Yes, describe:_____
14-27 Weeks: □ No □ Yes, describe:_____
28-40 Weeks: □ No □ Yes, describe:_____

If you use drugs and/or alcohol, are you interested in quitting?
0-13 Weeks: □ N/A □ Yes □ No
14-27 Weeks: □ N/A □ Yes □ No
28-40 Weeks: □ N/A □ Yes □ No

Intervention/Referral:
□ Reviewed/discussed STT HE: □ *Drug and Alcohol Use*_____ □ ***You Can Quit Using Drugs or Alcohol***_____ STT PSY: □ *Perinatal Substance Use/Abuse*_____ □ ***Your Baby Can't Say "No,"*** _____ □ ***Drugs and Alcohol, When You Want to STOP Using***_____
□ Notified provider of client's drug/alcohol use/date:_____
□ Referred to Alcoholics Anonymous (AA)/date: _____
□ Referred to Narcotics Anonymous (NA)/date: _____
□ Referred client to Medi-Cal drug treatment facility/date:_____
□ Referred to social worker/date:_____
□ Referred to Adult Children of Alcoholics, Al-Anon, or Alateen/ date:_____
_____
□ Referred to/date: _____

Client Name/ID:

39. Are you taking a prenatal vitamin every day? 0-13 Weeks: □ Yes □ No: 14-27 Weeks: □ Yes □ No 28-40 Weeks: □ Yes □ No	Intervention/Referral: □ Prenatal vitamins prescribed by provider/date: _____ □ Encouraged client to continue taking prenatal vitamins (and any other supplements recommended by provider)/date: _____
40. Are you taking any prescription, over-the-counter, or herbal medications? Examples: iron, pain medication, antidepressants, antacids, allergy medication, laxatives, or herbal remedies like yerba buena, ginseng, or manzanilla? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	□ Notified provider of any medication/supplement use to ensure safety during pregnancy/date:_____ □ Reviewed/discussed STT NUTR: □ *Prenatal Supplements: Vitamins, Minerals, and Other Supplements*_____ □ ***Take Prenatal Vitamins and Minerals***_____ □ ***If You Need Iron Pills***_____ □ ***You May Need Extra Calcium*** □ Referred to MotherToBaby: www.mothertobaby.org or 1-866-626-6847/date: _____ □ Referred to/date:_____

Pregnancy Care

41. Besides having a healthy baby, what are your goals for this pregnancy? _____	Intervention/Referral: □ Referred to/for:_____
42. Do you plan to have someone with you: During labor? 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____ When you first come home with the baby? 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Refer to childbirth classes/date:_____ □ Refer to home visitation program/date:_____ □ Referred to/date: _____
43. If you had a baby before, where was it delivered? □ N/A □ Clinic □ Hospital □ Home □ Other:_____ Did you or the baby have any problems? □ No □ Yes, explain:_____	Intervention/Referral: □ Notified provider of prior complications:_____ □ Provided information about the delivery hospital, including tours, registration, parking, and how to get there from her home
44. Have you ever lost any children? (miscarriage, stillbirth, SIDS, immigration, custody, etc.) □ No □ Yes, please explain:_____	Intervention/Referral: □ Reviewed/discussed STT PSY: □ *Perinatal Loss* □ ***Loss of Your Baby*** □ ***Ways to Remember Your Baby*** □ Referred to grief and loss resources □ Referred to grief support line at: 1-800-221-7437 □ Referred to social worker/date:_____ □ Referred to/date:_____
45. Do you have any questions about any prenatal tests or procedures? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed STT Appendix: *Prenatal Laboratory and Diagnostic Tests*_____ □ Answered questions/concerns:_____ □ Referred to provider for/date:_____

46. Have you experienced any of these discomforts during your pregnancy?

	0-13 Weeks		14-27 Weeks		28-40 Weeks
Edema (Swelling in hands/feet)	□		□		□
Diarrhea	□		□		□
Constipation	□		□		□
Nausea/Vomiting	□		□		□
Leg cramps	□		□		□
Hemorrhoids	□		□		□
Heartburn	□		□		□
Varicose veins	□		□		□
Headaches	□		□		□
Backaches	□		□		□
Vaginal bleeding	□		□		□
Cramping or contractions	□		□		□
None	□		□		□

Intervention/Referral:
□ Referred to/for:_____
□ Reviewed/discussed STT HE: □ *Preterm Labor*_____ □ ***If Your Labor Starts Too Early***_____ □ *Safe Exercise & Lifting*_____ □ ***Exercises To Do When You Are Pregnant***_____
STT NUTR: □ *Heartburn*_____ □ ***Heartburn: What You Can Do***_____ □ ***Heartburn: Should You Use Antacids?*** _____ □ *Nausea & Vomiting*_____ □ ***Nausea: Tips that Help***_____ □ ***Nausea: What To Do When You Vomit***_____ □ ***Nausea: Choose These Foods***_____ □ *Constipation*_____ □ ***Constipation: What You Can Do***_____ □ ***Constipation: What Products You Can and Cannot Use***_____ □ *Lactose Intolerance*_____ □ ***Do You Have Trouble with Milk Foods?***_____ □ ***Foods Rich in Calcium***_____
□ Additional education (describe in progress note if more space needed):_____
_____

Client Name/ID:

47. Does the doctor say there are any problems with this pregnancy? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed as needed: STT HE: □ *Preterm Labor*_____ □ ***If Your Labor Starts Too Early***_____ □ *Kick Counts*_____ □ ***Count Your Baby's Kicks***_____ □ *Labor Induction*_____ □ ***What You Need to Know About Labor Induction***_____ □ *Multiple Births - Twins and More*_____ □ ***Getting Ready for Multiples***_____ □ Referred to Prenatal Diagnostic Center (PDC)/date: _____ □ Referred to/date:_____
48. Compared to your previous pregnancies, is there anything you would like to change about the care you receive this time? □ N/A □ No □ Yes, explain:_____	Intervention/Referral: □ Notified provider of the client's requests or concerns □ Referred to/date: _____
49. Who has given you the most advice about your pregnancy? □ Mother □ Grandmother □ Partner □ Mother-in-law □ Friend □ No one □ Other:_____ 50. What are the most important things they have told you? Describe:_____	Intervention/Referral: □ Notified provider regarding any harmful advice □ Encouraged client to have support person participate in prenatal education/classes □ Referred to/date: _____
51. Do you have any traditions, customs or religious beliefs about pregnancy? □ No □ Yes: Please explain:_____ _____ If yes, Conflicts with medical recommendations? □ No □ Yes	Intervention/Referral: □ Reviewed/discussed STT First Steps: □ *Cultural Considerations* □ *Cross-Cultural Communication* □ *Clients with Alternative Health Care Experiences* □ Refer to provider for:_____
52. Would you like to become pregnant in the next 18 months? 14-27 Weeks: □ Yes □ No 28-40 Weeks: □ Yes □ No	Intervention/Referral: □ Discussed the importance of spacing 18 months between pregnancies/date: ____ _____ □ Reviewed/discussed STT HE: *Family Planning Choices*_____ □ Referred to provider to discuss the effectiveness of her preferred birth control method, pregnancy spacing, and effects of contraceptives on breastfeeding/date: _____ □ Encouraged client to talk to an OB or family planning provider about birth control methods that are less detectable (such as a shot, implant, or an IUD with the strings trimmed). □ Provided informed consent on sterilization and 30 day waiting period (if client's choice)/date:_____ □ Referred to/date:_____
53. Has your partner ever pressured you to become pregnant, interfered with your birth control, or refused to wear a condom? □ Never □ Sometimes □ Often	
54. Do you plan to use birth control after this pregnancy? 14-27 Weeks: □ No □ Undecided □ If yes, what method(s): Most effective methods (when used correctly) □ IUD □ Vasectomy □ Patch □ Implant □ Injection/shot □ Ring □ Tubal ligation □ Pills Less effective methods (higher failure rate) □ Condoms □ Diaphragm □ Abstinence □ Spermicides □ Cervical cap □ Withdrawal □ Fertility awareness methods □ Other:_____ 28-40 Weeks: □ No □ Undecided □ If yes, what method(s): Most effective methods (when used correctly) □ IUD □ Vasectomy □ Patch □ Implant □ Injection/shot □ Ring □ Tubal ligation □ Pills Less effective methods (higher failure rate) □ Condoms □ Diaphragm □ Abstinence □ Spermicides □ Cervical cap □ Withdrawal □ Fertility awareness methods □ Other:_____	

Client Name/ID:

55. These questions help us identify any risk factors for diseases like chlamydia, gonorrhea, herpes, hepatitis C, or HIV:			
Have you or your partner recently had sex with anybody else?	□ Yes	□ Unsure	□ No
Have you or any partners ever had an STD?	□ Yes	□ Unsure	□ No
Have you ever had sex while using alcohol or drugs?	□ Yes	□ Unsure	□ No
Have you or any partners exchanged sex for drugs, money, or shelter?	□ Yes	□ Unsure	□ No
Have you or any partners ever shared needles?	□ Yes	□ Unsure	□ No

56. Any change in HIV/STI risk status?
14-27 Weeks: □ Yes □ No
28-40 Weeks: □ Yes □ No

Intervention/Referral:
□ Notified the provider of risky sexual behaviors or symptoms of STIs/date:_____
□ Reviewed/discussed STT HE: □ *STIs (Sexually Transmitted Infections)*_____ □ *HIV and Pregnancy*_____ □ ***What You Should Know About STDs***_____ □ ***What You Should Know About HIV***_____ □ ***You Can Protect Yourself and Your Baby from STDs***_____
□ Referred to Los Angeles County STD Program Hotline for more information and referrals to STD clinics and HIV test sites in Los Angeles County: English/Spanish: 1-800-758-0880/date:_____
□ Referred to confidential/anonymous STD testing location/date: _____
_____

Educational Interests

57. How do you like to learn new things?
□ Text messages/apps □ One-on-one education
□ Reading/handouts □ Videos
□ Group classes □ Other:_____

Intervention/Referral:
□ Signed up for Text4Baby by texting BABY or (BEBE for Spanish) to 511411
□ Provided education in client's preferred learning methods

58. Will someone be able to attend prenatal classes with you?
□ No
□ Unsure
□ Yes, who? _____

Intervention/Referral:
□ Encouraged the client to share prenatal education materials with a support person like the father of the baby, friend, parent, or close relative

59. Do you have any physical, mental, or emotional conditions, such as learning disabilities, Attention-Deficit/Hyperactivity Disorder, depression, hearing or vision problems that may affect the way you learn?
□ No □ Yes:_____

Intervention/Referral:
□ Contact the client's Health Plan or visit Medi-Cal's website for more information about hearing and/or vision services and eligibility
□ Referred to/date:_____

60. Do you have experience with pregnancy, prenatal care, labor & delivery, postpartum self-care, and infant care and safety?
□ Yes □ No

Intervention/referral:
□ Enrolled in Text4Baby by texting BABY or (BEBE for Spanish) to 511411
□ Reviewed/discussed STT HE Handouts: □ ***Pregnant? Steps for a Healthy Baby*** □ ***Keep Your New Baby Safe and Healthy***
□ Referred to home visitation program/date: _____
□ Referred to group education classes/date: _____

61. Would you like information about the following topics?	0-13 Weeks		14-27 Weeks		28-40 Weeks	Date Education Provided	Teaching Method(s)
How your baby grows (fetal development)	□		□		□		
How your body changes during pregnancy	□		□		□		
Habits for a healthy pregnancy/baby	□		□		□		
What happens during labor/delivery	□		□		□		
Preparing for the delivery hospital	□		□		□		
Helping your child(ren) get ready for a new baby	□		□		□		
How to take care of yourself after the baby comes	□		□		□		
Breastfeeding	□		□		□		
How to take care of your baby (infant health & safety)	□		□		□		
Infant development	□		□		□		
Circumcision	□		□		□		
Immunizations needed during pregnancy (flu and Tdap)	□		□		□		
Birth control methods	□		□		□		

Client Name/ID:

62. Do you plan on receiving Tdap vaccine in your 3rd trimester?	
14-27 Weeks: □ Yes □ No □ Unsure	Intervention/Referral: □ Provided education on the benefits of Tdap in the 3rd trimester
28-40 Weeks: □ Yes □ No □ Unsure	Intervention/Referral: □ Provided additional education on the benefits of Tdap in the 3rd trimester □ Referred for Tdap/date: _____ □ Tdap administered/date: _____ □ Client plans to receive Tdap after delivery □ Client declines Tdap
63. Is there anything else that you would like to learn? _____ _____	Intervention/Referral: □ Provided education on: _____ _____

Nutrition: Anthropometric

64. Weight gain in last pregnancy: _____ lbs. □ Unknown □ N/A 65. Pre-pregnant weight: _____ lbs. Height: _____ Recommended weight gain goal for this pregnancy: Single Pregnancy □ Underweight: 28-40 lbs □ Normal weight: 25-35 lbs □ Overweight: 15-25 lbs □ Obese: 11-20 lbs Twin Pregnancy □ Normal: 37-54 lbs □ Overweight: 31-50 lbs □ Obese: 25-42 lbs	Intervention/Referral: □ Refer to STT NUTR: *Weight Gain During Pregnancy*- Section: "*How to Determine Gestational Weight Gain Goals and Assess Weight Gain"* □ Review/discussed STT NUTR Handout: ***MyPlate for Moms*** Underweight: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* – Section: "*Underweight"* □ Recommended regular meals and larger portions □ Discussed weight gain goal per month = 3-4 lbs for single pregnancy Overweight: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* – Section: "*Overweight"* □ Recommended smaller portions, more fruits and vegetables, and low/nonfat foods □ Discussed weight gain goal per month = 2-3 lbs after 16th week for single pregnancy Obese: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* – Section: " *Obese"* □ Recommended smaller portions, more fruits and vegetables, and low/nonfat foods □ Discussed weight gain goal per month = 2.5 lbs after 16th week for single pregnancy
66. Net Weight Gain 0-13 Weeks: _____lbs. □ Adequate □ Inadequate □ Excessive □ Weight Loss 14-27 Weeks: _____lbs. □ Adequate □ Inadequate □ Excessive □ Weight Loss 28-40 Weeks: _____lbs. □ Adequate □ Inadequate □ Excessive □ Weight Loss	Intervention/Referral □ Determined client's recommended net weight gain per STT NUTR: *Weight Gain During Pregnancy* □ Provided education about age-related nutritional needs/date: _____ □ If excessive weight gain, reviewed/discussed STT NUTR: ***Tips to Slow Weight Gain***_____ □ Recommended low fat foods, more water, and less sugary drinks like soda and juice □ If inadequate weight gain (or if weight loss), reviewed/discussed STT NUTR: ***Tips to Gain Weight*** _____ □ Recommended more frequent, calorie-dense meals □ Notified provider/date: _____ □ Referred to registered dietitian for/date:_____ □ Discussed risks associated with weight gain/loss:_____ _____

Client Name/ID:

Nutrition: Biochemical

67. 0-13 Weeks: Date blood drawn: _____ Hgb: _____ (<11g/L) Hct: _____ (<33%) Glucose: _____ MCV: _____ 14-27 Weeks: Date blood drawn: _____ Hgb: _____ (<10.5g/L) Hct: _____ (<32%) Glucose: _____ MCV: _____ 28-40 Weeks: Date blood drawn: _____ Hgb: _____ (<11g/L) Hct: _____ (<33%) Glucose: _____ MCV: _____ **OGTT** Initial Prenatal Visit *(if applicable)* Date:_____ Fasting: _____ 1 Hr: _____ 2 Hr: _____ □ N/A 24-28 weeks Date :_____ Fasting: _____ 1 Hr: _____ 2 Hr: _____	Intervention/Referral: □ Consult with provider on abnormal lab values and education interventions/date:_____ □ Anemia, iron prescribed/date: _____ □ Referred to/date: _____

Nutrition: Clinical

68. Current serious infections? (Ex: Kidney infection, HIV, TB, etc.) 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Referred to registered dietitian/date:_____ □ Referred to provider/date:_____ □ Referred to/date: _____
69. Anemia 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR: *Iron Deficiency and Other Anemias*_____ □ For Iron Deficiency Anemia, reviewed/discussed STT NUTR: □ ***Get the Iron You Need_____*** □ ***Iron Tips_____*** □ ***Iron Tips – Take Two!_____*** □ ***My Action Plan for Iron_____*** □ For Folic Acid Deficiency Anemia, reviewed/discussed: STT NUTR: □ ***Get the Folic Acid You Need_____*** □ ***Folic Acid: Every Woman, Every Day_____*** □ For Vitamin B_{12} Deficiency Anemia: reviewed/discussed STT NUTR: □ Vegetarian Eating_____ □ ***When You Are Vegetarian: What You Need to Know_____*** □ ***Vitamin B_{12} is Important_____*** □ Referred to registered dietitian/date:_____ □ Referred to provider/date:_____
70. Diabetes Pre-pregnancy: □ No □ Yes Past pregnancy: □ No □ Yes Current pregnancy: 0-13 Weeks: □ No □ Yes 14-27 Weeks: □ No □ Yes 28-40 Weeks: □ No □ Yes	Intervention/Referral: □ Discussed importance of keeping all prenatal appointments and labs, as well as maintaining a healthy diet and moderate exercise/date:_____ □ Reviewed/discussed STT GDM: □ *Gestational Diabetes Mellitus (GDM)* □ ***MyPlate for Moms for Gestational Diabetes_____*** □ ***If You Have Diabetes While You Are Pregnant: Questions You May Have_____*** □ ***If You Have Diabetes While You Are Pregnant: Ways to Lower Your Stress_____*** □ Referred to diabetes specialist or California Diabetes and Pregnancy Program (CDAPP) Sweet Success Affiliate/date:_____ □ Referred to registered dietitian/date: _____

Client Name/ID:

71. Hypertension Pre-pregnancy: □ No □ Yes Past pregnancy: □ No □ Yes Current pregnancy: 0-13 Weeks: □ No □ Yes 14-27 Weeks: □ No □ Yes 28-40 Weeks: □ No □ Yes 72. History of poor pregnancy outcome (low birth weight, preterm labor/delivery, large for gest. age) □ No □ Yes: _____ 73. Other medical/OB problems? (Ex: thyroid, cancer, lupus, etc.) 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Discussed importance of keeping all health care provider appointments/date: _____ □ Reviewed/Discussed STT HE: ***Signs and Symptoms of Heart Disease During Pregnancy and Postpartum*** □ Referred to MotherToBaby for information on medications and maternal medical conditions. The client or provider can call 1-866-626-6847 or visit www.mothertobaby.org /date:_____ □ Referred to registered dietitian/date:_____ □ Referred to provider/date:_____
74. Pregnancy interval < 18 months? □ Yes □ No 75. High parity? (≥ 4 births) □ Yes □ No	Intervention/Referral: □ Discussed the importance of a healthy diet to get the nutrients and calories she needs □ Discussed the importance of taking prenatal vitamins every day □ Discussed increased risk of low birth weight, preterm delivery and the pregnancy interval recommended by her healthcare provider
76. Multiple gestation? □ Yes □ No	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Multiple Births—Twins and More*, □ ***Getting Ready for Multiples*** □ ***Baby Products: Discounts and Coupons*** □ ***If Your Labor Starts Too Early*** □ Referred to registered dietitian/date:_____
77. Are you currently breastfeeding? □ Yes □ No	Intervention/Referral: □ Referred to provider due to history of miscarriage or preterm labor □ Discussed the importance of adequate food intake and meeting weight gain goals each month □ Referred to registered dietitian/date:_____

Nutrition: Dietary

78. Have your eating habits changed since you've been pregnant? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR: ***MyPlate for Moms*** _____ □ Referred to/date:_____
79. Do you ever crave/eat any of the following: □ Yes: Ice, freezer frost, corn starch, dirt, paint chips, plaster, clay, pottery, paste, other:_____ □ No	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Pica*, □ ***MyPlate for Moms*** □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____
80. a) Number of meals/day:_____ b) Meals often skipped? □ Yes □ No c) Number of snacks/day:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR Handout: ***MyPlate for Moms*** and discussed importance of eating foods from all of the different food groups, and the need to eat meals and snacks at regular times throughout the day □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____
81. Who does the following in your home? a) Buys food:_____ b) Cooks/prepares food:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Getting Healthy Foods*, □ ***Tips for Healthy Food Shopping*** □ ***You Can Buy Healthy Food on a Budget*** □ ***You Can Stretch Your Dollars: Choose These Easy Meals*** □ Reviewed/discussed STT NUTR: □ *Cooking & Food Storage* □ *Food Safety* □ ***Tips for Cooking and Storing Food*** □ ***Don't Get Sick From the Foods You Eat*** □ ***Eat Fish Safely – Tips*** □ ***Checklist for Food Safety*** □ ***Lower Your Chances of Eating Food with Unsafe Chemicals in Them*** □ ***Tips for Keeping Foods Safe***

Client Name/ID:

82. Are you on any special diet (medical diet, personal diet, etc.)? 0-13 Weeks: □ Yes, explain:_____ □ No 14-27 Weeks: □ Yes, explain:_____ □ No 28-40 Weeks: □ Yes, explain:_____ □ No	Intervention/Referral: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* and discussed her specific weight gain goals_____ □ Reviewed/discussed STT NUTR: ***MyPlate for Moms*** _____ □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____
83. Any food allergies? □ No □ Yes:_____ Any foods/beverages you avoid? □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Lactose Intolerance* □ ***Do You Have Trouble with Milk Foods?*** □ ***Foods Rich in Calcium*** □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____
84. Are you vegetarian or vegan? □ No □ Yes: Do you eat: □ Milk Products □ Eggs □ Nuts □ Beans □ Chicken/Fish	Intervention/Referral: □ Notified provider client is Vegan/date:_____ □ Reviewed/discussed STT NUTR: □ *Vegetarian Eating* □ ***When You Are a Vegetarian: What You Need to Know*** □ ***Vitamin B12 is Important*** □ Referred to/date:_____
85. 0-13 Weeks: a) How do you plan to feed your baby? □ Breastfeed □ Formula □ Breastfeed + Formula □ Undecided b) Have you ever breastfed or tried to breastfeed? □ If yes, for how long? _____ □ No □ N/A c) Did you breastfeed for as long as you wanted? □ Yes □ No, explain:_____ □ N/A	Intervention/Referral: □ Discussed benefits of breastfeeding and risks of formula feeding and supplementation/date: _____ □ Reviewed/discussed STT NUTR: □ *Breastfeeding* □ *Tips for Addressing Breastfeeding Concerns*_____ □ ***My Birth Plan***_____ WIC Handout: □ ***How Does Formula Compare to Breastmilk?***_____ □ Referred to WIC/date:_____ □ Referred to breastfeeding education classes/date:_____ □ Referred to/date:_____
14-27 Weeks: a) What do you think about breastfeeding your new baby? □ Not interested □ Thinking about it □ Wants to □ Definitely will □ Other: _____ b) What questions do you have about feeding your baby? _____	Intervention/Referral: □ Answered breastfeeding questions/concerns □ Reviewed/discussed STT NUTR: □ *Breastfeeding* □ *Tips for Addressing Breastfeeding Concerns* □ ***My Birth Plan*** _____ □ ***My Action Plan for Breastfeeding*** □ Referred to WIC/date:_____ □ Referred to breastfeeding education classes:_____ □ Referred to/date:_____
28-40 Weeks: a) How do you plan to feed your baby during the first month? □ Breastfeed □ Formula □ Breastfeed + Formula b) If you are going to breastfeed, who can you go to for breastfeeding help? _____ c) What questions do you have about feeding your baby? _____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Breastfeeding* □ *Tips for Addressing Breastfeeding Concerns* □ *What to Expect While Breastfeeding: Birth to Six Weeks* □ ***My Action Plan for Breastfeeding*** □ ***My Birth Plan*** □ ***Nutrition and Breastfeeding: Common Questions and Answers*** □ Provided education on safe formula preparation and feeding □ Discussed how supplementing with formula can decrease milk production □ Referred to WIC/date:_____ □ Referred to breastfeeding education classes/date:_____ □ Referred to/date:_____

Client Name/ID:

86. Diet intake assessment completed:

0-13 Weeks: □ Perinatal Food Group Recall (PFGR) □ 24-hour Perinatal Dietary Recall □ Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: ☐ Yes ☐ No	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ ***MyPlate for Moms*** □ ***My Nutrition Plan for Moms*** □ Referred to CalFresh _____ □ Referred to WIC _____ □ Referred to food bank _____ □ Referred to registered dietitian/date:_____ □ Notified provider/date:_____
14-27 Weeks: □ Perinatal Food Group Recall (PFGR) □ 24-hour Perinatal Dietary Recall □ Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: ☐ Yes ☐ No	Intervention/Referral - Update: □ Reviewed/discussed STT NUTR: □ ***MyPlate for Moms*** □ ***My Nutrition Plan for Moms*** □ Referred to CalFresh _____ □ Referred to WIC _____ □ Referred to food bank _____ □ Referred to registered dietitian/date:_____ □ Notified provider/date:_____
28-40 Weeks: □ Perinatal Food Group Recall (PFGR) □ 24-hour Perinatal Dietary Recall □ Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: ☐ Yes ☐ No	Intervention/Referral - Update: □ Reviewed/discussed STT NUTR: □ ***MyPlate for Moms*** □ ***My Nutrition Plan for Moms*** □ Referred to CalFresh _____ □ Referred to WIC _____ □ Referred to food bank _____ □ Referred to registered dietitian/date:_____ □ Notified provider to/date:_____

Coping Skills

87. Are you currently having problems/concerns with any of the following?

	0-13 Weeks	14-27 Weeks	28-40 Weeks
Divorce/separation	□	□	□
Recent death	□	□	□
Illness (cancer, abnormal Pap smear, etc.)	□	□	□
Unemployment	□	□	□
Immigration	□	□	□
Legal	□	□	□
Probation/parole	□	□	□
Child Protective Services/DCFS	□	□	□
Other:_____	□	□	□
None	□	□	□

Intervention/Referral:
□ Reviewed/discussed: STT PSY: □ *Financial Concerns*_____ □ *Legal/Advocacy Concerns*_____ □ *New Immigrant*_____ □ *Emotional or Mental Health Concerns* _____
□ Referred to legal assistance (free or low cost):_____
□ Referred to social worker/date: _____
□ Referred to home visitation program/date: _____
□ Referred to/date:_____

88. What things in your life do you feel good about?
_____

89. What things in your life would you like to change?
_____

90. Who do you turn to for emotional support?
□ FOB/partner □ Family member □ Friend
□ Other:_____

91. What do you do when you are upset?
_____

92. What do you do when you and your partner have disagreements?
_____

Intervention/Referral:
□ Reviewed/discussed:_____
_____
□ Referred to provider/date: _____
□ Referred to social worker/date: _____
□ Referred to/date:_____
_____

Client Name/ID:

93. Patient Health Questionnaire 9 (PHQ-9)	
0-13 Weeks: Total Score: □ 0-4 (None – Minimal) □ 5-9 (Mild) □ 10-14 (Moderate) □ 15-19 (Moderate Severe) □ 20-27 (Severe)	Intervention/Referral: □ Notified provider of PHQ-9 score of 10 or higher □ Reviewed/discussed STT PSY: □ *Emotional/Mental Health Concerns* □ *Depression*_____ □ ***How Bad Are Your Blues***?_____ □ Reviewed the "Speak Up When You're Down" brochure □ Encouraged client to inform provider if symptoms worsen □ Referred to Postpartum Support International at: 1-800-944-4773 □ Referred to home visitation program/date: _____ □ Referred to mental health clinic/date:_____ □ Referred to social worker/date:_____ □ Referred to mental health urgent care clinic/date: _____ _____ □ Contacted psychiatric mobile response services at: 1-800-854-7771/date: _____ □ Contacted 911 or local law enforcement agency/date: _____
14-27 Weeks: Total Score: □ 0-4 (None – Minimal) □ 5-9 (Mild) □ 10-14 (Moderate) □ 15-19 (Moderate Severe) □ 20-27 (Severe)	Intervention/Referral: □ Notified provider of PHQ-9 score of 10 or higher □ Reviewed/discussed STT PSY: □ *Emotional/Mental Health Concerns* □ *Depression*_____ □ ***How Bad Are Your Blues***?_____ □ Reviewed the "Speak Up When You're Down" brochure □ Encouraged client to inform provider if symptoms worsen □ Referred to Postpartum Support International at: 1-800-944-4773 □ Referred to home visitation program/date: _____ □ Referred to mental health clinic/date:_____ □ Referred to social worker/date:_____ □ Referred to mental health urgent care clinic/date: _____ _____ □ Contacted psychiatric mobile response services at: 1-800-854-7771/date: _____ □ Contacted 911 or local law enforcement agency/date: _____
28-40 Weeks: Total Score: □ 0-4 (None – Minimal) □ 5-9 (Mild) □ 10-14 (Moderate) □ 15-19 (Moderate Severe) □ 20-27 (Severe)	Intervention/Referral: □ Notified provider of PHQ-9 score of 10 or higher □ Reviewed/discussed STT PSY: □ *Emotional/Mental Health Concerns* □ *Depression*_____ □ ***How Bad Are Your Blues***?_____ □ Reviewed the "Speak Up When You're Down" brochure □ Encouraged client to inform provider if symptoms worsen □ Referred to Postpartum Support International at: 1-800-944-4773 □ Referred to home visitation program/date: _____ □ Referred to mental health clinic/date:_____ □ Referred to social worker/date:_____ □ Referred to mental health urgent care clinic/date: _____ _____ □ Contacted psychiatric mobile response services at: 1-800-854-7771/date: _____ □ Contacted 911 or local law enforcement agency/date: _____
94. Are you currently receiving services from a local agency such as case management, home visiting, counseling, etc.? □ No □ Yes, please explain:_____	Intervention/referral: □ Obtained client's signed consent to contact agency and coordinate services using an authorization to release information form □ Agency information:_____ □ Client declined case coordination
95. Have you ever attended individual or group counseling or therapy? □ No □ If Yes, when and why? _____ Have you ever been prescribed medications for emotional problems (sadness, anger, nervousness, irritability, difficulty sleeping, etc.)? □ No □ If Yes, when and why? _____ Have you ever been hospitalized for emotional problems, or thinking about hurting yourself, etc.? □ No □ If Yes, when and why? _____	Intervention/referral: □ Reviewed/discussed STT PSY: □ *Emotional or Mental Health Concerns* □ *Depression.* □ Notified provider of history:_____ □ Referred to home visitation program/date: _____ □ Referred to social worker /date:_____ □ Referred to mental health clinic/date: _____ □ Referred to/date: _____

Client Name/ID:

96. Have you ever been emotionally or physically abused by your partner or someone important to you? □ No □ Yes, please explain:_____ 97. Do you ever feel afraid of your partner? □ No □ Yes, please explain:_____ 98. Within the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone? □ No □ Yes, by whom? _____ How many times? _____	Intervention/referral: □ Informed client of mandatory reporting requirement if (1) she has current physical injuries from abuse, or (2) she is under the age of 18/date:_____ □ Notified provider immediately:_____ □ Danger Assessment form completed by provider/date:_____ □ Contacted local law enforcement agency/date: _____ □ Completed Suspicious Injury Report/date:_____ □ Referred to domestic violence shelter/date:_____ □ Referred to local law enforcement agency/date:_____ □ Reviewed/discussed STT PSY: □ *Spousal/Intimate Partner Abuse*_____ □ ***Cycle of Violence*** □ ***Safety When Preparing to Leave*** □ *Child Abuse and Neglect* (if under age of 18)/date:_____ □ Referred to LA County Domestic Violence Hotline: 1-800-978-3600/date:_____ or the National Domestic Violence Hotline: 1-800-799-7233/date:_____ □ Reviewed/discussed STT HE: *Family Planning Choices*/date: _____ □ Referred to family planning provider/date:_____ □ Referred to social worker/date: _____ □ Referred to/date: _____
99. Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? 0-13 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 14-27 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 28-40 Weeks: □ No □ Yes, by whom? _____ How many times? _____	
100. Within the last year, has anyone forced you to have sexual activities? 0-13 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 14-27 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 28-40 Weeks: □ No □ Yes, by whom? _____ How many times? _____	
101. Are your children, or have your children ever been, victims of physical abuse, sexual abuse, or neglect? □ N/A □ No □ Yes, please explain:_____	Intervention/referral: □ Notified provider: _____ □ Contacted LA County Child Protection Hotline: 1-800-540-4000/date: _____ □ Child Abuse Report filed/date: _____ □ Reviewed/discussed STT PSY: *Child Abuse and Neglect* □ Referred to/date:_____

Initial Assessment Completed By:_____
Name & CPSP Title Date Minutes

2nd Trimester Reassessment Completed By:_____
Name & CPSP Title Date Minutes

3rd Trimester Reassessment Completed By:_____
Name & CPSP Title Date Minutes

Client Name/ID:

Provider Signature: _____ Date: _____

Client Strengths: _____

_____

Prenatal Individualized Care Plan Summary

#	Problem/Risk/Concern	Client Goal	Updates & Outcomes
			2
			3
			P
			2
			3
			P
			2
			3
			P
			2
			3
			P
			2
			3
			P

Client Name/ID:

CPSP Progress Note

Each entry must include date, time (in minutes), staff signature and CPSP title

Client Name/ID: