

Comprehensive Perinatal Services Program

Prenatal Assessment/Reassessment and Individualized Care Plan

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

Client Name: Example Rogers Date of Birth: _____

Health Plan: _____ ID Number: Y-9147d

Provider: Paperwork Health Hospital: Paperwork Demo Hospital

Case Coordinator: Casey Coordination EDD: _____

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

Personal Information

Individualized Care Plan

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

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

Economic Resources

<p>13. a) Are you currently working or going to school? <input type="checkbox"/> No <input type="checkbox"/> Yes, Type of school/work: _____ Hours per week: _____</p> <p>b) Do you plan to work or go to school while you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Do you plan to return to work/school after baby is born? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Intervention/Referral: <input type="checkbox"/> Referred to school program for pregnant/parenting teens (if under 18 and has not graduated or passed the California High School Proficiency Exam/date: _____ <input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Workplace Safety</i>, <input type="checkbox"/> Keep Safe at Work STT PSY: <input type="checkbox"/> <i>Financial Concerns</i>, <input type="checkbox"/> <i>Legal/Advocacy Concerns</i> <input type="checkbox"/> Reviewed/discussed pumping/storing breastmilk per STT NUTR: <i>Breastfeeding</i> <input type="checkbox"/> Referred to childcare/date: _____ <input type="checkbox"/> Referred to/date: _____</p>																																																																							
<p>14. Will the father of the baby provide financial support for you and the baby? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure</p> <p>Other sources of financial help: _____</p>	<p>Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT PSY: <i>Financial Concerns</i> for information on the father's requirement to pay child support <input type="checkbox"/> Reviewed/discussed STT PSY: <i>Legal/Advocacy Concerns</i> <input type="checkbox"/> Referred to LA County Child Support Services: 1-866- 901-3212/date: _____ <input type="checkbox"/> Referred to/date: _____</p>																																																																							
<p>15. Are you receiving any of the following?</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th></th> <th colspan="2">0-13 Weeks</th> <th colspan="2">14-27 Weeks</th> <th colspan="2">28-40 Weeks</th> <th rowspan="2">Referral & Date</th> </tr> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>WIC</td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>CalFresh (Food Stamps)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>CalWORKs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Medi-Cal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Emergency Food Assistance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Pregnancy disability benefits</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Other: _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </tbody> </table>			0-13 Weeks		14-27 Weeks		28-40 Weeks		Referral & Date		Yes	No	Yes	No	Yes	No	WIC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		CalFresh (Food Stamps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		CalWORKs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Medi-Cal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Emergency Food Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Pregnancy disability benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	0-13 Weeks		14-27 Weeks		28-40 Weeks		Referral & Date																																																																	
	Yes	No	Yes	No	Yes	No																																																																		
WIC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																		
CalFresh (Food Stamps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																		
CalWORKs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																		
Medi-Cal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																		
Emergency Food Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																		
Pregnancy disability benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																		
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																		
<p>16. a) In the past 12 months, have you worried whether your food would run out before you got money to buy more? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>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? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p>	<p>Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>Getting Healthy Foods</i> <input type="checkbox"/> <i>Tips for Healthy Food Shopping</i> <input type="checkbox"/> <i>You Can Buy Healthy Food on a Budget</i> <input type="checkbox"/> <i>You Can Stretch Your Dollars: Choose These Easy Meals and Snacks</i> <input type="checkbox"/> Referred to food bank/date: _____ <input type="checkbox"/> Referred to/date: _____</p>																																																																							

Client Name/ID:

Housing

<p>17. What type of housing do you currently live in?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Trailer Park <input type="checkbox"/> Public Housing <input type="checkbox"/> Other: _____ </div> <div style="width: 48%;"> <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Farm Worker Camp <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Car </div> </div> <p>Any changes in housing?</p> <p><u>14-27 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p><u>28-40 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p>	<p>Intervention/Referral:</p> <input type="checkbox"/> Reviewed/discussed STT PSY: <i>Financial Concerns</i> _____ <input type="checkbox"/> Referred to LA County Housing Resource Center: 1-877-428-8844/date: _____ <input type="checkbox"/> Referred to emergency housing/homeless shelter/date: _____ <input type="checkbox"/> Referred to LA County Lead Poisoning Prevention Hotline: 1-800-LA-4-LEAD/date: _____ <input type="checkbox"/> Referred to/date: _____																																																																												
<p>18. Members of household (not including client):</p> <p>Number of adults: _____</p> <p>Relationship to client: _____</p> <p>Number of children: _____</p> <p>Relationship to client: _____</p>																																																																													
<p>19. Was your house or apartment built before 1978?</p> <p><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>Is there chipping or peeling paint inside or outside the home?</p> <p><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Unsure</p>																																																																													
<p>20. Is your current housing safe and adequate for you and your children)?</p> <p><u>0-13 Weeks:</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, explain: _____</p> <p><u>14-27 Weeks:</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, explain: _____</p> <p><u>28-40 Weeks:</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, explain: _____</p>																																																																													
<p>21. Do any of your children or your partner's children live with someone else?</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, explain: _____</p>	<p>Intervention/Referral:</p> <input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Parenting Stress</i> <input type="checkbox"/> <i>New Immigrant</i> <input type="checkbox"/> <i>Legal/Advocacy Concerns</i> <input type="checkbox"/> Referred to National Parent Helpline: 1-855-427-2736/date: _____ <input type="checkbox"/> Referred to family support/counseling or child abuse prevention program/date: _____ <input type="checkbox"/> Referred to/date: _____																																																																												
<p>22. Do you have the following where you live?</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">0-13 Wks</th> <th colspan="2">14-27 Wks</th> <th colspan="2">28-40 Wks</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>Toilet</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Stove/place to cook</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Tub/shower</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Electricity</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Refrigerator</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Hot/cold water</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Phone</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Smoke detectors</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>Windows that open/close</td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> </tbody> </table>		0-13 Wks		14-27 Wks		28-40 Wks		Yes	No	Yes	No	Yes	No	Toilet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stove/place to cook	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tub/shower	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Electricity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Refrigerator	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hot/cold water	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Phone	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Smoke detectors	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Windows that open/close	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<p>Intervention/Referral:</p> <input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>Cooking and Food Storage</i> _____ <input type="checkbox"/> <i>Food Safety</i> _____ <input type="checkbox"/> When You Cannot Refrigerate: Choose These Foods _____ <input type="checkbox"/> Tips for Cooking and Storing Food _____ <input type="checkbox"/> Don't Get Sick From the Foods You Eat _____ <input type="checkbox"/> Referred to LA County Housing Resource Center 1-877-428-8844/date: _____ <input type="checkbox"/> Referred to HUD 1-213-894-8000/date: _____ <input type="checkbox"/> Referred to Housing Rights Center 1-800-477-5977/date: _____ <input type="checkbox"/> Referred to local fire department/date: _____ <input type="checkbox"/> Referred to social worker/date: _____
		0-13 Wks		14-27 Wks		28-40 Wks																																																																							
	Yes	No	Yes	No	Yes	No																																																																							
Toilet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Stove/place to cook	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Tub/shower	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Electricity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Refrigerator	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Hot/cold water	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Phone	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Smoke detectors	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
Windows that open/close	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																							
<p>23. Do you have a gun in your home?</p> <p><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how is it stored? _____</p>	<p>Intervention/Referral:</p> <input type="checkbox"/> Provided information about safe gun storage <input type="checkbox"/> Educated client that unwanted guns may be turned in to most local law enforcement agencies/date: _____ <input type="checkbox"/> Referred to/date: _____																																																																												

Client Name/ID:

Transportation

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

Current Health Practices

<p>28. Do you have a primary care doctor for you and your family?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed to STT Appendix: <i>Introduction to Managed Care</i></p> <p><input type="checkbox"/> Referred to/date: _____</p>								
<p>29. Do you have a doctor for your baby?</p> <p>14-27 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____</p> <p>28-40 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Infant Safety and Health</i> _____</p> <p><input type="checkbox"/> When Your Newborn Baby is Ill _____ <input type="checkbox"/> Your Baby Needs to be Immunized _____</p> <p><input type="checkbox"/> Referred to CHDP provider/date: _____</p>								
<p>30. a) Have you been to a dentist in the last 6 months?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Do you have any problems with your teeth, gums or mouth such as toothaches, bleeding gums, or a bad taste or smell?</p> <p>0-13 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p>14-27 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p>28-40 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE <input type="checkbox"/> <i>Oral Health During Pregnancy</i> _____</p> <p><input type="checkbox"/> Prevent Gum Problems When You Are Pregnant _____</p> <p><input type="checkbox"/> See a Dentist When You Are Pregnant _____ <input type="checkbox"/> Keep Your Teeth and Mouth Healthy! Protect Your Baby Too _____</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p> <p><input type="checkbox"/> Referred to dentist/date: _____</p>								
<table border="1"> <tr> <td>31. How many total hours do you sleep at night?</td> <td>How many total min/hours do you nap during the day?</td> </tr> <tr> <td>0-13 Weeks: _____</td> <td>0-13 Weeks: _____</td> </tr> <tr> <td>14-27 Weeks: _____</td> <td>14-27 Weeks: _____</td> </tr> <tr> <td>28-40 Weeks: _____</td> <td>28-40 Weeks: _____</td> </tr> </table>	31. How many total hours do you sleep at night?	How many total min/hours do you nap during the day?	0-13 Weeks: _____	0-13 Weeks: _____	14-27 Weeks: _____	14-27 Weeks: _____	28-40 Weeks: _____	28-40 Weeks: _____	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Discuss using extra pillows for joint or back discomfort. To improve relaxation, offer deep breathing, visualization and relaxation techniques/date: _____</p> <p><input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Emotional or Mental Health Concerns</i> _____ <input type="checkbox"/> <i>Depression</i> _____ <input type="checkbox"/> How Bad are Your Blues? _____</p> <p><input type="checkbox"/> Referred to/date: _____</p>
31. How many total hours do you sleep at night?	How many total min/hours do you nap during the day?								
0-13 Weeks: _____	0-13 Weeks: _____								
14-27 Weeks: _____	14-27 Weeks: _____								
28-40 Weeks: _____	28-40 Weeks: _____								
<p>32. Do you exercise?</p> <p>0-13 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes, type/frequency: _____</p> <p>14-27 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes, type/frequency: _____</p> <p>28-40 Weeks: <input type="checkbox"/> No <input type="checkbox"/> Yes, type/frequency: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Safe Exercise and Lifting</i> _____</p> <p><input type="checkbox"/> Exercises To Do When You Are Pregnant _____ <input type="checkbox"/> Stay Active When You Are Pregnant _____ <input type="checkbox"/> Keep Safe When You Exercise _____</p> <p><input type="checkbox"/> Referred to provider for discussion of vigorous exercise (lifting heavy weights, running, etc.) during pregnancy/date: _____</p> <p><input type="checkbox"/> Referred to exercise or fitness resources that are low-cost/date: _____</p>								

Client Name/ID: _____

<p>33. Are you currently smoking or using any tobacco products (including hookah or vaping)?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> No</td> <td style="width: 75%; padding: 5px;"> <input type="checkbox"/> Yes: How much per day? _____ For how many years? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td style="padding: 5px;"><u>14-27 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> No</td> <td style="padding: 5px;"> <input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td style="padding: 5px;"><u>28-40 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> No</td> <td style="padding: 5px;"> <input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table> <p>34. Are you often around other people who smoke cigarettes or any other tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Do you use or have exposure to any of the following at home, work, or doing any hobbies?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%;">0-13 Weeks</th> <th style="width: 10%;">14-27 Weeks</th> <th style="width: 10%;">28-40 Weeks</th> </tr> </thead> <tbody> <tr><td>Products like bleach, ammonia or oven cleaners</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Pesticides or chemicals</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Cooking with clay pottery</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Jewelry making</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Glue</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Fertilizers</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Cat litter box</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Pet turtles or reptiles</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Rodents</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Douching</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Hot baths or saunas</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>X-Rays</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Other: _____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>None</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>36. At home, where do you store the following?: Vitamins _____ Medications _____ Cleaning Supplies _____</p> <p>Are these things kept out of the reach of children? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. Have either of your parents had a drug or alcohol problem? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____</p> <p>Does your partner have a problem with drugs or alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____</p> <p>Have you had a problem with drugs or alcohol in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____</p> <p>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.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> No</td> <td style="width: 75%; padding: 5px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="padding: 5px;"><u>14-27 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> No</td> <td style="padding: 5px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="padding: 5px;"><u>28-40 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> No</td> <td style="padding: 5px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> </table> <p style="text-align: center;">If you use drugs and/or alcohol, are you interested in quitting?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> N/A</td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> Yes</td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;"><u>14-27 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> N/A</td> <td style="padding: 5px;"><input type="checkbox"/> Yes</td> <td style="padding: 5px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;"><u>28-40 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> N/A</td> <td style="padding: 5px;"><input type="checkbox"/> Yes</td> <td style="padding: 5px;"><input type="checkbox"/> No</td> </tr> </table>	<u>0-13 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes: How much per day? _____ For how many years? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>14-27 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>28-40 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No		0-13 Weeks	14-27 Weeks	28-40 Weeks	Products like bleach, ammonia or oven cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pesticides or chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cooking with clay pottery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fertilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cat litter box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pet turtles or reptiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Douching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot baths or saunas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>0-13 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____	<u>14-27 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____	<u>28-40 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____	<u>0-13 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>14-27 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>28-40 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Tobacco Use</i> _____ <input type="checkbox"/> You Can Quit Smoking _____ <input type="checkbox"/> <i>Secondhand Tobacco Smoke</i> _____</p> <p><input type="checkbox"/> 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: _____</p> <p><input type="checkbox"/> Referred to smoking cessation program/date: _____</p> <p><input type="checkbox"/> Referred to provider for additional counseling on smoking cessation/date: _____</p> <hr/> <p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Cautions While Pregnant</i> _____</p> <p><input type="checkbox"/> <i>Workplace Safety</i> _____ <input type="checkbox"/> Pregnant? Steps for a Healthy Baby _____ <input type="checkbox"/> Keep Safe at Work _____</p> <p><input type="checkbox"/> Referred to provider to discuss any harmful exposure to chemicals at home or work/date: _____</p> <p><input type="checkbox"/> Referred to MotherToBaby: www.mothersbaby.org or 1-866-626-6847/date: _____</p> <hr/> <p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE Handout: Keep Your New Baby Safe</p>
<u>0-13 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes: How much per day? _____ For how many years? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																									
<u>14-27 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																									
<u>28-40 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																									
	0-13 Weeks	14-27 Weeks	28-40 Weeks																																																																																								
Products like bleach, ammonia or oven cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Pesticides or chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Cooking with clay pottery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Jewelry making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Glue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Fertilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Cat litter box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Pet turtles or reptiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Douching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Hot baths or saunas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																								
<u>0-13 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____																																																																																									
<u>14-27 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____																																																																																									
<u>28-40 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____																																																																																									
<u>0-13 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								
<u>14-27 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								
<u>28-40 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								
<p>37. Have either of your parents had a drug or alcohol problem? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____</p> <p>Does your partner have a problem with drugs or alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____</p> <p>Have you had a problem with drugs or alcohol in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____</p> <p>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.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> No</td> <td style="width: 75%; padding: 5px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="padding: 5px;"><u>14-27 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> No</td> <td style="padding: 5px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="padding: 5px;"><u>28-40 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> No</td> <td style="padding: 5px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> </table> <p style="text-align: center;">If you use drugs and/or alcohol, are you interested in quitting?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> N/A</td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> Yes</td> <td style="width: 10%; padding: 5px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;"><u>14-27 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> N/A</td> <td style="padding: 5px;"><input type="checkbox"/> Yes</td> <td style="padding: 5px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;"><u>28-40 Weeks:</u></td> <td style="padding: 5px;"><input type="checkbox"/> N/A</td> <td style="padding: 5px;"><input type="checkbox"/> Yes</td> <td style="padding: 5px;"><input type="checkbox"/> No</td> </tr> </table>	<u>0-13 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____	<u>14-27 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____	<u>28-40 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____	<u>0-13 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>14-27 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>28-40 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Drug and Alcohol Use</i> _____</p> <p><input type="checkbox"/> You Can Quit Using Drugs or Alcohol _____ STT PSY: <input type="checkbox"/> <i>Perinatal Substance Use/Abuse</i> _____ <input type="checkbox"/> Your Baby Can't Say "No," _____</p> <p><input type="checkbox"/> Drugs and Alcohol, When You Want to STOP Using _____</p> <p><input type="checkbox"/> Notified provider of client's drug/alcohol use/date: _____</p> <p><input type="checkbox"/> Referred to Alcoholics Anonymous (AA)/date: _____</p> <p><input type="checkbox"/> Referred to Narcotics Anonymous (NA)/date: _____</p> <p><input type="checkbox"/> Referred client to Medi-Cal drug treatment facility/date: _____</p> <p><input type="checkbox"/> Referred to social worker/date: _____</p> <p><input type="checkbox"/> Referred to Adult Children of Alcoholics, Al-Anon, or Alateen/ date: _____</p> <p><input type="checkbox"/> Referred to/date: _____</p>																																																																					
<u>0-13 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____																																																																																									
<u>14-27 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____																																																																																									
<u>28-40 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe: _____																																																																																									
<u>0-13 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								
<u>14-27 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								
<u>28-40 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								

Client Name/ID:

Pregnancy Care

Page 6 of 17
Los Angeles County CPSP Prenatal Assessment/Reassessment and Individualized Care Plan 6/2017

Client Name/ID:

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

Client Name/ID:

55. These questions help us identify any risk factors for diseases like chlamydia, gonorrhea, herpes, hepatitis C, or HIV:				Intervention/Referral:	
Have you or your partner recently had sex with anybody else?	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure	<input type="checkbox"/> No	<input type="checkbox"/> Notified the provider of risky sexual behaviors or symptoms of STIs/date: _____	
Have you or any partners ever had an STD?	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure	<input type="checkbox"/> No	<input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>STIs (Sexually Transmitted Infections)</i> _____ <input type="checkbox"/> <i>HIV and Pregnancy</i> _____ <input type="checkbox"/> <i>What You Should Know About STDs</i> _____ <input type="checkbox"/> <i>What You Should Know About HIV</i> _____ <input type="checkbox"/> <i>You Can Protect Yourself and Your Baby from STDs</i> _____	
Have you ever had sex while using alcohol or drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure	<input type="checkbox"/> No	<input type="checkbox"/> 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: _____	
Have you or any partners exchanged sex for drugs, money, or shelter?	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure	<input type="checkbox"/> No	<input type="checkbox"/> Referred to confidential/anonymous STD testing location/date: _____	
Have you or any partners ever shared needles?	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure	<input type="checkbox"/> No		
56. Any change in HIV/STI risk status?					
14-27 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No					
28-40 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No					

Educational Interests

57. How do you like to learn new things?				Intervention/Referral:	
<input type="checkbox"/> Text messages/apps <input type="checkbox"/> One-on-one education <input type="checkbox"/> Reading/handouts <input type="checkbox"/> Videos <input type="checkbox"/> Group classes <input type="checkbox"/> Other: _____				<input type="checkbox"/> Signed up for Text4Baby by texting BABY or (BEBE for Spanish) to 511411 <input type="checkbox"/> Provided education in client's preferred learning methods	
58. Will someone be able to attend prenatal classes with you?				Intervention/Referral:	
<input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Yes, who? _____				<input type="checkbox"/> 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?				Intervention/Referral:	
<input type="checkbox"/> No <input type="checkbox"/> Yes: _____				<input type="checkbox"/> Contact the client's Health Plan or visit Medi-Cal's website for more information about hearing and/or vision services and eligibility <input type="checkbox"/> Referred to/date: _____	
60. Do you have experience with pregnancy, prenatal care, labor & delivery, postpartum self-care, and infant care and safety?				Intervention/referral:	
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Enrolled in Text4Baby by texting BABY or (BEBE for Spanish) to 511411 <input type="checkbox"/> Reviewed/discussed STT HE Handouts: <input type="checkbox"/> <i>Pregnant? Steps for a Healthy Baby</i> <input type="checkbox"/> <i>Keep Your New Baby Safe and Healthy</i> <input type="checkbox"/> Referred to home visitation program/date: _____ <input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
How your body changes during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Habits for a healthy pregnancy/baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
What happens during labor/delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preparing for the delivery hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Helping your child(ren) get ready for a new baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
How to take care of yourself after the baby comes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
How to take care of your baby (infant health & safety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Infant development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Circumcision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Immunizations needed during pregnancy (flu and Tdap)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Birth control methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Client Name/ID:

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

Nutrition: Anthropometric

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

Nutrition: Biochemical

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

Nutrition: Clinical

<p>68. Current serious infections? (Ex: Kidney infection, HIV, TB, etc.)</p> <p><u>0-13 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p><u>14-27 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p><u>28-40 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p> <p><input type="checkbox"/> Referred to provider/date: _____</p> <p><input type="checkbox"/> Referred to/date: _____</p>
<p>69. Anemia</p> <p><u>0-13 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p><u>14-27 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p><u>28-40 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT NUTR: <i>Iron Deficiency and Other Anemias</i> _____</p> <p><input type="checkbox"/> For Iron Deficiency Anemia, reviewed/discussed STT NUTR: <input type="checkbox"/> Get the Iron You Need _____ <input type="checkbox"/> Iron Tips _____ <input type="checkbox"/> Iron Tips – Take Two! _____ <input type="checkbox"/> My Action Plan for Iron _____</p> <p><input type="checkbox"/> For Folic Acid Deficiency Anemia, reviewed/discussed: STT NUTR: <input type="checkbox"/> Get the Folic Acid You Need _____ <input type="checkbox"/> Folic Acid: Every Woman, Every Day _____</p> <p><input type="checkbox"/> For Vitamin B₁₂ Deficiency Anemia: reviewed/discussed STT NUTR: <input type="checkbox"/> Vegetarian Eating _____ <input type="checkbox"/> When You Are Vegetarian: What You Need to Know _____ <input type="checkbox"/> Vitamin B₁₂ is Important _____</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p> <p><input type="checkbox"/> Referred to provider/date: _____</p>
<p>70. Diabetes</p> <p>Pre-pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Past pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Current pregnancy:</p> <p><u>0-13 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><u>14-27 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><u>28-40 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Discussed importance of keeping all prenatal appointments and labs, as well as maintaining a healthy diet and moderate exercise/date: _____</p> <p><input type="checkbox"/> Reviewed/discussed STT GDM: <input type="checkbox"/> <i>Gestational Diabetes Mellitus (GDM)</i> <input type="checkbox"/> MyPlate for Moms for Gestational Diabetes _____ <input type="checkbox"/> If You Have Diabetes While You Are Pregnant: Questions You May Have _____ <input type="checkbox"/> If You Have Diabetes While You Are Pregnant: Ways to Lower Your Stress _____</p> <p><input type="checkbox"/> Referred to diabetes specialist or California Diabetes and Pregnancy Program (CDAPP) Sweet Success Affiliate/date: _____</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p>

Client Name/ID:

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

Nutrition: Dietary

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

Client Name/ID: _____

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

Client Name/ID:

86. Diet intake assessment completed:	
<u>0-13 Weeks:</u> <input type="checkbox"/> Perinatal Food Group Recall (PFGR) <input type="checkbox"/> 24-hour Perinatal Dietary Recall <input type="checkbox"/> Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>MyPlate for Moms</i> <input type="checkbox"/> <i>My Nutrition Plan for Moms</i> <input type="checkbox"/> Referred to CalFresh _____ <input type="checkbox"/> Referred to WIC _____ <input type="checkbox"/> Referred to food bank _____ <input type="checkbox"/> Referred to registered dietitian/date: _____ <input type="checkbox"/> Notified provider/date: _____
<u>14-27 Weeks:</u> <input type="checkbox"/> Perinatal Food Group Recall (PFGR) <input type="checkbox"/> 24-hour Perinatal Dietary Recall <input type="checkbox"/> Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Intervention/Referral - Update: <input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>MyPlate for Moms</i> <input type="checkbox"/> <i>My Nutrition Plan for Moms</i> <input type="checkbox"/> Referred to CalFresh _____ <input type="checkbox"/> Referred to WIC _____ <input type="checkbox"/> Referred to food bank _____ <input type="checkbox"/> Referred to registered dietitian/date: _____ <input type="checkbox"/> Notified provider/date: _____
<u>28-40 Weeks:</u> <input type="checkbox"/> Perinatal Food Group Recall (PFGR) <input type="checkbox"/> 24-hour Perinatal Dietary Recall <input type="checkbox"/> Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Intervention/Referral - Update: <input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>MyPlate for Moms</i> <input type="checkbox"/> <i>My Nutrition Plan for Moms</i> <input type="checkbox"/> Referred to CalFresh _____ <input type="checkbox"/> Referred to WIC _____ <input type="checkbox"/> Referred to food bank _____ <input type="checkbox"/> Referred to registered dietitian/date: _____ <input type="checkbox"/> Notified provider to/date: _____

Coping Skills

87. Are you currently having problems/concerns with any of the following? <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%;">0-13 Weeks</th> <th style="width: 10%;">14-27 Weeks</th> <th style="width: 10%;">28-40 Weeks</th> </tr> </thead> <tbody> <tr><td>Divorce/separation</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Recent death</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Illness (cancer, abnormal Pap smear, etc.)</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Unemployment</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Immigration</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Legal</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Probation/parole</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Child Protective Services/DCFS</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Other: _____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>None</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>		0-13 Weeks	14-27 Weeks	28-40 Weeks	Divorce/separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Illness (cancer, abnormal Pap smear, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immigration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Probation/parole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child Protective Services/DCFS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed: STT PSY: <input type="checkbox"/> <i>Financial Concerns</i> _____ <input type="checkbox"/> <i>Legal/Advocacy Concerns</i> _____ <input type="checkbox"/> <i>New Immigrant</i> _____ <input type="checkbox"/> <i>Emotional or Mental Health Concerns</i> _____ <input type="checkbox"/> Referred to legal assistance (free or low cost): _____ <input type="checkbox"/> Referred to social worker/date: _____ <input type="checkbox"/> Referred to home visitation program/date: _____ <input type="checkbox"/> Referred to/date: _____
	0-13 Weeks	14-27 Weeks	28-40 Weeks																																										
Divorce/separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Recent death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Illness (cancer, abnormal Pap smear, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Immigration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Probation/parole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Child Protective Services/DCFS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
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? <input type="checkbox"/> FOB/partner <input type="checkbox"/> Family member <input type="checkbox"/> Friend <input type="checkbox"/> Other: _____ 91. What do you do when you are upset? _____ 92. What do you do when you and your partner have disagreements? _____	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed: _____ <input type="checkbox"/> Referred to provider/date: _____ <input type="checkbox"/> Referred to social worker/date: _____ <input type="checkbox"/> Referred to/date: _____																																												

Client Name/ID:

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

Client Name/ID:

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

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:

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

This image shows a full page of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page, typical of notebook or legal stationery. There are no margins, text, or other markings on the page.