

Comprehensive Perinatal Services Program

Prenatal Assessment/Reassessment and Individualized Care Plan

Initial: _____ / _____
Date Weeks

2nd Trimester: _____ / _____
(14-27 Weeks) Date Weeks

3rd Trimester: _____ / _____
(28 Weeks – Delivery) Date Weeks

Client Name: Niko Dunk Date of Birth: _____

Health Plan: _____ ID Number: 5

Provider: _____ Hospital: _____

Case Coordinator: _____ 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 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 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 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 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 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 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: _____</p> <p>Language: _____</p> <p>Education: _____</p> <p>Age: _____</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;"> <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"/>	
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<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="" 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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: _____
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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?								
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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 style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black; padding: 2px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><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="border: 1px solid black; padding: 2px;"><u>14-27 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><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="border: 1px solid black; padding: 2px;"><u>28-40 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><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 style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">0-13 Weeks</th> <th style="width: 10%; text-align: center;">14-27 Weeks</th> <th style="width: 10%; text-align: center;">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 style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black; padding: 2px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>14-27 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>28-40 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> </table> <p style="margin-top: 10px;">If you use drugs and/or alcohol, are you interested in quitting?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black; padding: 2px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> N/A</td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes</td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>14-27 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> N/A</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>28-40 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> N/A</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> </tr> </table>	<u>0-13 Weeks:</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes : How much per day? 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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>
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<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 style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black; padding: 2px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>14-27 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>28-40 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes, describe: _____</td> </tr> </table> <p style="margin-top: 10px;">If you use drugs and/or alcohol, are you interested in quitting?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black; padding: 2px;"><u>0-13 Weeks:</u></td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> N/A</td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes</td> <td style="width: 10%; border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>14-27 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> N/A</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"><u>28-40 Weeks:</u></td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> N/A</td> <td style="border: 1px solid black; padding: 2px;"><input type="checkbox"/> Yes</td> <td style="border: 1px solid black; padding: 2px;"><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: _____																																																																																									
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<u>0-13 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								
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<u>28-40 Weeks:</u>	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																																																								

Client Name/ID:

Pregnancy Care

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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>
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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>

<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 <input checked="" 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> <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: _____
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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

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Client Name/ID:
