1. Date: 

2. Patient Label: 

3. Vital Signs: 
   Height: ___________ Weight: ___________
   BMI: ___________ Blood Pressure: ___________

4. Menses: 
   LMP ___________ Normal? Yes ❑ No ❑
   LNMP ___________

5. Gravida/Parity: 
   Gravida _____ T _____ P _____ A _____ L _____

6. Reproductive Life Planning: 
   Would you like to have any (or more) children? Yes ❑ No ❑
   How Many? _________ When? _________
   How important is it to you to prevent pregnancy (until then)? _________
   Notes: ________________________________________________
   ________________________________________________

7. Current Methods: ❑ OCP (type): ____________________________
   ❑ Depo ❑ Condoms ❑ Patch ❑ Nuva Ring
   ❑ IUD ❑ Implant ❑ BTL ❑ FABM
   Problems With Current Methods: __________________
   ________________________________________________

   Date Method Last Used: ____________________________ N/A ❑
   Unprotected Sex in Last Five Days: Yes ❑ No ❑

8. Current History: ❑ Yes ❑ No
   Tobacco and/or Electronic Nicotine Devices Use—Self and/or environment
   Alcohol/Drugs—Self and/or environment
   Medication Use: OTC/Prescription
   Chronic Medical Illness
   Physical Disability
   Mental Health
   Other: 

9. Immunization Education: ❑ Immunization schedule handout given with CDC guidelines.

10. Behavioral Health Assessment: 
   1. During the past two weeks, have you often been bothered by either of the following two problems? 
      a. Feeling down, depressed, irritable or hopeless ❑ Yes ❑ No ❑
      b. Little interest or pleasure in doing things ❑ Yes ❑ No ❑
   2. Are you in a relationship with a person who threatens or physically hurts you? Yes ❑ No ❑
   3. In the past year, have you been slapped, kicked or otherwise physically hurt by someone? Yes ❑ No ❑

11. Labs: 
   Pregnancy Test: Positive ❑ Negative ❑
   Other Labs Completed: ____________________________
   Notes: __________________________________________

12. NEGATIVE RESULTS: Education/Counseling
   ❑ Preconception Counseling Done (Base on vital signs and current history sections above)
   ❑ Methods of Contraception Reviewed
      By Tiered Approach N/A ❑
      Quick Start Method Offered N/A ❑
      Emergency Contraception Offered If
      Unprotected Sex in Past 5 Days N/A ❑
      Achieving Pregnancy Counseling Done N/A ❑
      Infertility Services Offered N/A ❑
      Folic Acid Supplement Recommended N/A ❑
      Contraceptive Method patient chose at the close of the visit
      OCP (type): ____________________________
      Depo ❑ Condoms ❑ Patch ❑ Nuva Ring
      IUD ❑ Implant ❑ BTL ❑ FABM ❑ None
      Declined all methods N/A ❑
      Other ____________________________

13. POSITIVE RESULTS: Education/Counseling* (Check All That Apply)
    Weeks Gestation: ____________ EDC: ____________
    ❑ Ectopic Pregnancy Warning Signs Discussed (Required for all positive results)
    ❑ Varicella Handout Given/Reviewed
    ❑ Prenatal Care Counseling (as requested by client)
       Healthy Pregnancy Behaviors Reviewed:
       ❑ Verbally Reviewed Healthy Pregnancy Behaviors
       ❑ Written Material Reviewed:
       This section is optional for FP clinic*. If the patient is undecided and requests pregnancy counseling in a FP clinic it can only be given by an MD or Advanced Practice Provider
       ❑ Prenatal Care Counseling (As requested by client)
       ❑ Adoption/Foster Care Counseling (As requested by client)
       ❑ Pregnancy Termination Counseling (As requested by client)
       Name/discipline of staff performing the nondirective pregnancy counseling: ____________________________
**14. POSITIVE RESULTS: Plan**

<table>
<thead>
<tr>
<th>Plan Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Presumptive Eligibility Completed</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>• Presumptive Eligibility Deferred to 1st Prenatal Appointment (ONLY IF Scheduled at Local Health Department’s Maternal Health Clinic)</td>
</tr>
<tr>
<td>• Prenatal Vitamins: 1 daily #30</td>
</tr>
<tr>
<td>• Flu Vaccine (as indicated)</td>
</tr>
<tr>
<td>• Social Support Assessed</td>
</tr>
</tbody>
</table>

**Notes:**

**Other:**

**Follow-Up Notes:**

**15. Referrals:**

<table>
<thead>
<tr>
<th>Referral Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family Planning Clinic at Local Health Department</td>
</tr>
<tr>
<td><strong>Family Planning Appointment Date:</strong></td>
</tr>
</tbody>
</table>

Prenatal Care referral is required for all positive pregnancy tests.

- Referral accepted by patient
- Referral declined by patient

<table>
<thead>
<tr>
<th>Clinic/Facility Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maternal Health Clinic at Local Health Department</td>
</tr>
<tr>
<td><strong>First Maternal Health Appointment Date:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinic/Facility Outside of Local Health Department</td>
</tr>
<tr>
<td><strong>Clinic/Facility Name:</strong></td>
</tr>
<tr>
<td><strong>Appointment Date:</strong></td>
</tr>
</tbody>
</table>

Presents with Ectopic Pregnancy Warning Signs

- Yes
- No

**If Yes to Above**

- Referral to Emergency Department STAT
- Department of Social Services/Adoption Services
- Intimate Partner Violence
- Substance Use Disorder
- WIC
- Mental Health
- Pregnancy Care Management
- Transportation
- Other:

**16. Follow-up Phone Number:**

**Signature:**

---

DHHS 4140 (Revised 10/2019)
WCH (Review 10/2021)