1. Last Name	First Name	MI

2. Patient Number										

3. Date of Birth (MM/DD/YYYY)										
	Month		Day		Year					

4. Race ☐ American Indian or Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Unknown ☐ White

5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American
☐ Hispanic Other ☐ Hispanic Puerto Rican
☐ Not Hispanic/Latino ☐ Unreported

6. Gender ☐ Female ☐ Male

7. County of Residence

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MATERNAL HEALTH HISTORY — PART C-1
Initial Psychosocial Screening

(TO BE SELF-ADMINISTERED

OR

COMPLETED BY STAFF)

Please complete the following questions. Put an X or check mark in the box for YES or NO, as it applies.

QUESTION	YES	NO
1. Are you currently living in a safe place?		
2. Do you have a working stove and refrigerator? Running water and indoor plumbing?		
3. Do you have any physical limitations or any problems hearing, reading, speaking? Do you have any learning disabilities?		
4. Have you experienced any type of major life event in the last year; such as, death of someone close, loss of job, housing worries, relationship issues, a major illness or a loved one in the military being deployed?		
5. Are there any reasons that you think might keep you from coming to your appointments? Transportation, work schedule, lack of child care, no family support?		
6. Complete PHQ-9.		
7. Within the past year have you been threatened or hit, slapped, kicked, spit on or otherwise physically hurt by anyone?		
8. Since you have been pregnant, have you been threatened or hit, slapped, kicked, spit on or otherwise physically hurt by anyone?		
9. If you did feel unsafe, do you know where you can go or have a trusted person to call?		
10. Within the last year, has anyone forced you into sexual acts which made you feel uncomfortable?		
11. Substance Use Screening: complete the Modified 5Ps form, if Pregnancy Risk Screening has not been completed.		
12. Do others smoke, use e-cigarettes or vape around you?		
13. Which of the following products have you used in the past 30 days? ☐ Cigarettes ☐ E-Cigarettes/vaping ☐ Cigars/Cigarillos ☐ Chewing tobacco ☐ Snuff ☐ Hookah ☐ Snus ☐ Strips ☐ Sticks/Orbs ☐ None ☐ Other		
14. If you could pick the best timing for your pregnancy, would you like to be pregnant: ☐ At another time ☐ Would not change it, my pregnancy was planned ☐ Not at all ☐ Would not change it, even though it was not planned		

Comments/Notes: _____

_____

_____

Interpreter Used ☐ **N/A** ☐ No ☐ Yes **Interpreter Name** _____

Staff Reviewer's Signature _____ **Date** _____

MATERNAL HEALTH HISTORY — PART C-1
Initial Psychosocial Screening Instructions

Purpose:	To assess and document initial psychosocial information on the prenatal patient.
Instructions:	The patient should complete items 1- 14. Staff should document results on the Interval Psychosocial Screening form. Maternal Health History, Part C-2. Documentation of referrals and follow up should occur in the narrative notes.
Case Management:	No to #1 or #2, a referral to OBCM and/or community resources should be completed.
Communication Barriers:	Yes to #3 requires further clinician response and evaluation to establish patient's needs and ensure understanding and connection to resources.
Stressors, Losses and Support:	Yes to #4 or #5 a referral to OBCM, LCSW or community resources should occur.
Depression:	PHQ-9 should be completed. Based on the PHQ-9 score, a referral could be needed to LCSW or Local Management Entity (LME) /community mental health resource. Score should be documented in narrative notes or per Health Department policy.
Interpersonal Violence:	Yes, to any or all #7, #8, #9, and/or #10 requires further clinician response and evaluation to establish (1) patient's current safety, (2) need for a safety plan, and/or (3) referral to community resources. Health Department policy should guide this intervention. A referral to OBCM should be completed.
Substance Use:	#11, if a CCNC Risk Screening from **has not** been completed, patient should complete the Modified 5P's to evaluate for substance use.
Tobacco:	#12, #13, based on responses requires further clinician response including the 5A's and evaluation for smoking cessation.
Intendedness:	#14 if responses "at another time" or "not at all" are recorded, further clinician response is required, including evaluation for possible referral to OBCM or LCSW.
Disposition:	This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.
Location:	Go to the following link to access this form and print as needed: https://whb.ncpublichealth.com/provPart/forms.htm