

## MATERNAL HEALTH HISTORY — PART C-2

### Interval Psychosocial Screening and Results

*(TO BE FILLED OUT BY STAFF DURING APPROPRIATE INTERVALS, FOR EXAMPLE DURING 2<sup>nd</sup> OR 3<sup>rd</sup> TRIMESTER, POSTPARTUM OR AS NEEDED)*

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)		
	Month	Day Year
4. Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White		
5. Ethnic Origin <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported		
6. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
7. County of Residence		

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

	2 <sup>nd</sup> Trimester	3 <sup>rd</sup> Trimester	Postpartum
<i>SINCE THE LAST TIME WE ASKED YOU, HAVE YOU...</i>	Date: / /	Date: / /	Date: / /
<b>Depression</b>			
1. Over the last two weeks have you had little interest or pleasure in doing things?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2. Over the last two weeks have you felt down, depressed or hopeless?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3. At any time in the past two weeks have you had thoughts you would be better off dead and or hurting yourself or someone else in some way for at least several days in the last two weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4. If yes to Questions 1, 2, or 3, then completion of PHQ-9 is required.	Score _____	Score _____	
5. Full EPDS or PHQ-9 completed.			Score _____
<b>Interpersonal Violence</b>			
5. Since we last saw you have you been threatened, hit, slapped, kicked, or spit on?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Since we last saw you have you been forced into sexual acts which made you feel uncomfortable?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. Do you feel your home is a safe place to bring your baby?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Tobacco Use</b>			
8. Since we last saw you have you used any tobacco or nicotine products; such as, cigarettes, cigars, chewing tobacco, snuff, e-cigarettes or vape products?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Substance Use</b>			
9. Since the last time we saw you, have you drunk alcohol, used any illegal drugs or taken any prescription medications not given to you by a doctor?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes 5P's completed

RECORD RESULTS:	INITIAL (see previous form)	Additional Screening	2 <sup>nd</sup> Trimester	3 <sup>rd</sup> Trimester	Postpartum
Referral Done	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Referred to:	<input type="checkbox"/> PCM <input type="checkbox"/> LCSW <input type="checkbox"/> Mental Health <input type="checkbox"/> Nurse Family Partnership <input type="checkbox"/> Other: _____				
Referral Date:	/ /	/ /	/ /	/ /	/ /
Resolved Date:	/ /	/ /	/ /	/ /	/ /

Comments/Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Interpreter Used:  N/A  No  Yes Interpreter Name \_\_\_\_\_  
2<sup>nd</sup> Trimester — Staff Reviewer's Signature \_\_\_\_\_ Date \_\_\_\_\_  
3<sup>rd</sup> Trimester — Staff Reviewer's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Postpartum — Staff Reviewer's Signature \_\_\_\_\_ Date \_\_\_\_\_

## MATERNAL HEALTH HISTORY — PART C-2 Interval Psychosocial Screening and Results

**Purpose:** To assess and document psychosocial information on a prenatal patient after the initial intake, during the postpartum period.

**Instructions:**

**Depression:** Yes to #1 or #2, PHQ-9 should be completed. Based on the PHQ-9 score a referral could be a needed to LCSW, or Local Management Entity/community mental health resources.

Yes to #3, **immediate crisis intervention** should occur guided by Health Department policy.

**Interpersonal Violence:** Yes, for any or all, #6, #7, #8 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.

**Tobacco Use:** Yes to #9 requires further clinician response including the 5 A's and evaluation for smoking cessation.

**Substance Use:** Yes to #10 requires further clinician response including the Modified 5 P's and evaluation for substance use. Modified 5 Ps Form: <https://whb.ncpublichealth.com/provPart/forms.htm>

If a patient is receiving OBCM services, inform the OBCM of any positive findings.

**Record Results:** Used to document referral information. The results from the initial psychosocial screening form should be recorded in the "initial" column. Additional Screening Column is used to record results from screenings conducted during a different interval.

**Comments:** Added as deemed necessary & appropriate by clinician.

**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>