Pregnancy Assessment – *to be completed by pregnancy care manager*

Demographics:

MID____________________ Medicaid Status: Currently on Medicaid Not on Medicaid

Patient Last Name: ________________ First Name: _______________ Middle initial: ____

SSN: ______________ Age:_______ DOB: ____/____/_________

Race: ________________ Ethnicity: ____________________

Patient Address:____

County of Residence: ________________________

Home Phone: _____________ Alternate Phone ________________ Best time to call: __________

Email: ____________________________

Emergency Contact: __________________ Emergency Contact Phone: ______________

Primary Care Provider Name: ____

Primary Care Practice Name: ____

Primary Care Practice Phone: ____________________

Prenatal Care Provider Name: ____

Prenatal Care Practice: ____

Prenatal Care Practice Phone: ________________________

Sources of Information:________________ (e.g., prenatal care provider, patient, other:_________________)

Due date: ____/____/________

Due date established by what criteria? (check all that apply)

- ❑ Last Menstrual Period (LMP)
- ❑ First Trimester Ultrasound
- ❑ Second Trimester Ultrasound
- ❑ Other (Specify) ________________

Gravidity:_____ Parity: ____ _____ _____ _____

Height _____(feet) ______(inches) Pre-pregnancy weight ______ (pounds)

Referral Source: ***(Check all that apply.)***

- ❑ Pregnancy Medical Home (PMH)
- ❑ Prenatal care provider (not PMH)
- ❑ Primary Care Provider
- ❑ CCNC Data Report
- ❑ Local Health Department
- ❑ Other (specify): __________

Family/ Support System

Father of baby involved: ☐Yes ☐No

Comments:____

Name	Age	Relationship to patient	Home phone number	Alternate phone number

Pregnancy Conditions

***Multi-fetal Gestation** ☐**Yes** ☐**No**

Comments:____

***Fetal complications** ☐**Yes** ☐**No**

☐Yes ☐No Fetal anomaly, (Comments: ____)

☐Yes ☐No Fetal chromosomal abnormality, (Comments: __________________________)

☐Yes ☐No Intrauterine growth restriction/IUGR (Comments: ______________________)

☐Yes ☐No Oligohydramnios (Comments:_____________________________________)

☐Yes ☐No Polyhydramnios (Comments:______________________________________)

☐Yes ☐No Other, specify:____

***Chronic conditions (which may complicate pregnancy)** ☐**Yes** ☐**No**

☐Yes ☐No Asthma (Comments____)

☐Yes ☐No Diabetes (Comments: ____)

☐Yes ☐No Hypertension (Comments:_____________________________________)

☐Yes ☐No HIV (Comments: ____)

☐Yes ☐No Mental Illness (Comments: ___________________________________)

☐Yes ☐No Renal Disease (Comments:____________________________________)

☐Yes ☐No Seizure Disorder (Comments: _________________________________)

☐Yes ☐No Systemic Lupus Erythematosus (Comments:_______________________)

☐Yes ☐No Other, specify:____

Hypertensive Disorders of Pregnancy: ☐Yes ☐No If yes, check all that apply:

☐Yes ☐No Eclampsia (Comments: _______________________________________)

☐Yes ☐No Preeclampsia (Comments: ____________________________________)

☐Yes ☐No Gestational Hypertension (Comments: ___________________________)

☐Yes ☐No HELLP Syndrome (Comments: _________________________________)

***Current/recent (month prior to learning of pregnancy) use of drugs or alcohol** ☐Yes ☐No

Comments: ____

***Late Entry to Prenatal Care** ☐Yes ☐No

Comments: ____

Cervical Insufficiency ☐Yes ☐No

Comments: ____

Gestational Diabetes ☐Yes ☐No

Comments: ____

Vaginal Bleeding in 2nd Trimester ☐Yes ☐No

Comments: ____

Short Inter-pregnancy Interval (< 12 months between last delivery and current pregnancy) ☐Yes ☐No

Comments: ____

Current Sexual Transmitted Infection ☐Yes ☐No

Comments: ____

Recurrent Urinary Tract Infections ☐Yes ☐No

Comments: ____

Communication Barriers ☐Yes ☐No ***If yes, check all that apply***:

☐Yes ☐No Literacy (Comments: ____)

☐Yes ☐No Disability (Comments: ____)

☐Yes ☐No Non-English speaking Primary Language: ______________________________

Obstetric History

***Preterm birth (< 37 completed weeks)** ☐Yes ☐No

Comments:____

Gestational age (s) of previous preterm births: ______ weeks; _______weeks; _______ weeks

☐Yes ☐No Result of spontaneous preterm labor and/or preterm rupture or membranes?

☐Yes ☐No Current singleton pregnancy?

***Low Birth Weight (<2500g)** ☐Yes ☐No

Comments: ____

***Very Low Birth Weight (<1500g)** ☐Yes ☐No

Comments: ____

Fetal Death (>20 weeks) ☐Yes ☐No

Comments: ____

Neonatal death (within first 28 days of life) ☐Yes ☐No

Comments: ____

Second Trimester Pregnancy Loss ☐Yes ☐No

Comments: ____

Three or More First Trimester Pregnancy Losses ☐Yes ☐No

Comments: ____

Post-partum Depression ☐Yes ☐No

Comments: ____

Cervical Insufficiency ☐Yes ☐No

Comments: ____

Gestational Diabetes ☐Yes ☐No

Comments: ____

Hypertensive Disorders of Pregnancy ☐Yes ☐No If yes, check all that apply:

☐Yes ☐No Eclampsia (Comments:____)

☐Yes ☐No Preeclampsia (Comments: ____)

☐Yes ☐No Gestational Hypertension (Comments: ____)

☐Yes ☐No HELLP Syndrome (Comments: ____)

Psychosocial Issues

Patient concerns about her pregnancy ☐Yes ☐No
(Comments:____
____)

Intendedness of pregnancy: ***Check only one.***

- ❑ Wanted to be pregnant sooner
- ❑ Wanted to be pregnant now
- ❑ Wanted to be pregnant later
- ❑ Did not want to be pregnant now or at any time in the future
- ❑ Doesn't know

Tobacco Use** ***Check only one.

- ❑ A. Never smoked
- ❑ B. Stopped smoking BEFORE finding out she was pregnant, and not smoking now
- ❑ *C. Stopped smoking AFTER finding out she was pregnant, and not smoking now
- ❑ *D. Smokes some now, but cut down on the number of cigarettes SINCE finding out she was pregnant
- ❑ *E. Smokes regularly now, about the SAME as before finding out she was pregnant

If C, D or E:

- Advised to quit or stay quit: ☐Yes ☐No
- Not ready to quit ☐Yes ☐No
- Ready to quit ☐Yes ☐No ***If yes, check any of the following.***
  - ❑ Used a problem-solving method
  - ❑ Assessed social environment
  - ❑ Provided pregnancy-specific materials
  - ❑ Referred to Quit Line (Proactive Referral)
  - ❑ Arranged follow up contact

In-home Exposure to Secondhand smoke ☐Yes ☐No

Comments: ____

Occupational Exposure to Secondhand Smoke ☐Yes ☐No

Comments: ____

Substance Abuse

Did any of your parents have a problem with alcohol or other drug use? ☐Yes ☐No

Do any of your friends have a problem with alcohol or other drug use? ☐Yes ☐No

Does your partner have a problem with alcohol or other drug use? ☐Yes ☐No

In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? ☐Yes ☐No

Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs? ☐Not at all ☐Rarely ☐Sometimes ☐Frequently

In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?

☐Not at all ☐Rarely ☐Sometimes ☐Frequently

If yes to <u>any</u> of the above 5 questions, assess patient for current and recent use of alcohol and other drugs:

In the month before you knew you were pregnant about how many days a week did you usually drink beer, wine or liquor?

☐Every day ☐3-6 days/wk ☐1-2 days/wk ☐less than 1 day/wk ☐Not at all

In the month before you knew you were pregnant about how many days a week did you usually use any drug such as marijuana, cocaine or heroin, or use prescription drugs in a way that is different from how they were prescribed or that were prescribed for another person?

☐Every day ☐3-6 days/wk ☐1-2 days/wk ☐less than 1 day/wk ☐Not at all

And now, about how many days a week do you usually drink beer, wine or liquor?

☐Every day ☐3-6 days/wk ☐1-2 days/wk ☐less than 1 day/wk ☐Not at all

And now, about how many days a week do you usually use any drug such as marijuana, cocaine or heroin, or use prescription drugs in a way that is different from how they were prescribed or that were prescribed for another person?

☐Every day ☐3-6 days/wk ☐1-2 days/wk ☐less than 1 day/wk ☐Not at all

Comments:____

____

____

***Violence/Sexual Abuse:**

- Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
  ☐Yes ☐No

Comments: ____

- Are you in a relationship with a person who threatens or physically hurts you? ☐Yes ☐No

Comments:____

- Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐Yes ☐No

Comments: ____

Anxiety ☐Yes ☐No (Comments: ____)

Bipolar disorder ☐Yes ☐No (Comments: ______________________________________)

Depression ☐Yes ☐No (Comments: ____)

- Do you experience little interest or pleasure in doing things? ☐Yes ☐No
- Are you feeling down, depressed or hopeless? ☐Yes ☐No
- ***If yes to either question, administer PHQ-9.***

Eating Disorder ☐Yes ☐No (Comments: ____)

PTSD ☐Yes ☐No (Comments: ____)

Schizophrenia ☐Yes ☐No (Comments: ____)

Behavior Pattern ☐Agitated ☐Appropriate ☐Nervous ☐Sad/nothing cheers ☐Wandering
(Comments: ____)

Have a mental health worker/counselor ☐Yes ☐No (Comments: __________________________)

If yes, Mental Health Worker/Counselor Name: __________________________________

Phone: _______________________ Company: _____________________________________

Social/Housing Issues

Describe Living Situation: *Choose only one.*

- ❑ *Homeless
- ❑ Lives alone with consistent family support
- ❑ Lives alone with friend
- ❑ Lives alone with no support
- ❑ Lives with family
- ❑ Lives with one available, willing and able caregiver
- ❑ Lives with partner/significant other
- ❑ Primary caregiver is elderly, disabled or ill
- ❑ *Unstable/unsafe housing

Comments: ____

Financial Concerns: ☐Yes ☐No (Comments: ___________________________________)

Educational Needs: ☐Yes ☐No (Comments: ___________________________________)

Employment Needs: ☐Yes ☐No (Comments: ___________________________________)

Support System Needs and/or Family Issues: ☐Yes ☐No (Comments: _______________ ____)

Child Care Needs: ☐Yes ☐No (Comments: ___________________________________)

Transportation Needs: ☐Yes ☐No (Comments: ___________________________________)

Legal Concerns: ☐Yes ☐No (Comments: ___________________________________)

Nutrition issues

Hungry in the last 12 months because could not afford enough food ☐Yes ☐No (Comments: ____)

WIC Needed ☐Yes ☐No (Comments: ___________________________________)

WIC Referral Made ☐Yes ☐No (Comments: ___________________________________)

Medications

Prescribed Medications: ☐Yes ☐No (Comments: ____)

List current medications: ____

____

____

____

Drug Allergies: _______________________________________

Pharmacy (Most frequently used): ________________________ Phone:_____________________

17P Treatment: ☐Yes ☐No (Comments: ____)

Healthcare

Health Insurance/Medicaid Needs: ☐Yes ☐No (Comments: __________________________
____)

Pregnancy Medical Home/prenatal care: ☐Has ☐Needs **Last Visit** __/__/__
Comments: ____

Date of first prenatal visit: __/__/__

Weeks of gestation when prenatal care began: ______ weeks

Primary Care Provider: ☐ Has ☐Needs **Last Visit**__/__/__
Comments: ____

Childbirth Education: ☐Has ☐ Needs
Comments: ____

Dentist: ☐Has ☐Needs **Last Visit**__/__/__
Provider Name: _____________________________________ Phone: _______________________
Comments: ____

Eye Doctor: ☐Has ☐Needs **Last Visit**__/__/__
Provider Name: _____________________________________ Phone:__________________________
Comments: ____

Family Planning:
Past experience with family planning methods____
Desire for family planning method after pregnancy______________________________________

Utilization

Adherence Issues: ☐Yes ☐No

If yes, describe difficulty: ____

Patient needs help with: (***Check all that apply.***)

- ☐ Keeping prenatal appointments
- ☐ Adhering to diet
- ☐ Managing medications
- ☐ Adhering to medication regimen
- ☐ Bed rest

Other Agencies

Name: ___________________________________ Agency:______________________________________

Type of Assistance:_________________________________ Phone: ________________________________

Name: ___________________________________ Agency:______________________________________

Type of Assistance:_________________________________ Phone: ________________________________

Name: ___________________________________ Agency:______________________________________

Type of Assistance:_________________________________ Phone: ________________________________

Postpartum

Pregnancy Outcome (*Check only one.*):

- ❑ Fetal death >20 weeks
- ❑ Live birth
- ❑ Spontaneous abortion
- ❑ Therapeutic abortion

If live birth, provide the information below:

Gestational Age at Delivery: ____*weeks* _____*days*

Date of postpartum clinic visit: __/__/____

Comments: ____

Referral for Primary Care Made: ❑Yes ❑No

Postpartum WIC Certification for Mother: ❑Yes ❑No
Comments: ____

WIC certification for newborn: ❑Yes ❑No
Comments: ____

Postpartum referral for continuing Medicaid eligibility made: ❑Yes ❑No
Comments: ____

Family planning: ❑Has ❑ Needs (Comments: ____)

Breastfeeding Support: ❑Has ❑ Needs Breastfeeding Referral Made: ❑ Yes ❑No
Comments: ____

Infant: Last Name__________________; First Name_________________________

Infant Medicaid ID#:__________________

Infant's Date of Birth: __/__/__

Infant admitted to NICU/NCCC/Special Care Nursery: ❑Yes ❑No
Hospital: ____

Infant referral to CC4C and/or Early Intervention: ❑ Yes ❑No

Date Infant Certified for Medicaid: __/__/__

Pediatric care for newborn: ❑Yes ❑No Provider Name________________________

Date of Assessment: __/__/__

Name of person completing assessment:_________________________

Signature: _______________________

<u>Note</u>: Completion of items in GREEN identifies priority risk factors and essential demographic information. Patients meeting priority risk criteria need a complete assessment for care management needs.