

Comprehensive Perinatal Services Program Prenatal Assessment/Reassessment and Individualized Care Plan

Initial: _____ / _____ 2nd Trimester: _____ / _____ 3rd Trimester: _____ / _____
Date Weeks (14-27 Weeks) Date Weeks (28 Weeks – Delivery) Date Weeks

Client Name: _____ Date of Birth: _____

Health Plan: _____ ID Number: _____

Provider: _____ Delivery Hospital: _____

Case Coordinator: _____ EDD: _____

Dx. OB High Risk Condition: _____ Gravida: _____ Para: _____

What is your Race or Ethnicity: White Hispanic, Latino, or Spanish origin Black or African American Asian
 American Indian or Alaska Native Native Hawaiian or other Pacific Islander Some other race; specify: _____ Refused

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 type="checkbox"/> 18-34 years</p> <p><input type="checkbox"/> 35 years or older</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Child abuse report filed (if younger than 18 and abuse suspected)/date: _____</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"/> 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 social worker/date: _____</p> <p><input type="checkbox"/> Referred to/date: _____</p> <p><input type="checkbox"/> Discussed importance of genetic counseling (if over 35)</p>
<p>2. Are you: <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><input type="checkbox"/> Referred to social worker/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"/> Discussed the benefits and importance of regular prenatal care for her and the baby</p> <p><input type="checkbox"/> Provided assistance in transferring her care</p> <p><input type="checkbox"/> Referred to/date: _____</p>
<p>5. Delivery Hospital: _____</p> <p><input type="checkbox"/> Informed/agrees</p> <p><input type="checkbox"/> Informed/disagrees</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Educated per protocol</p> <p><input type="checkbox"/> Explained the risk of not delivering at the affiliated hospital</p> <p><input type="checkbox"/> Notified provider/date: _____</p> <p><input type="checkbox"/> Other _____</p>
<p>6. 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>7. 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>

8. Which of the following best describes how you read: <input type="checkbox"/> Like to read and read often <input checked="" type="checkbox"/> Can read, but don't read very often <input type="checkbox"/> Can't read	Intervention/Referral: <input type="checkbox"/> Provided verbal/visual/written information appropriate for client's ability <input type="checkbox"/> Reviewed STT FS: <i>Low Literacy Skills</i> <input type="checkbox"/> Referred to Public Library or Adult Literacy Program/date: _____ <input type="checkbox"/> Referred to/date: _____	
9. Father/Partner/Caregiver of baby: Name: _____ Language: _____ Education: _____ Age: _____	Intervention/Referral: <input type="checkbox"/> Referred to legal assistance/date: _____ <input type="checkbox"/> Provided information on declaring paternity (per STT PSY: <i>Teen Pregnancy and Parenting</i> – even if client is not a teen) <input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Child Abuse and Neglect</i> <input type="checkbox"/> <i>Legal/Advocacy Concerns</i> <input type="checkbox"/> Child Abuse Report filed (based on client/partner ages or suspected abuse)/date: _____ <input type="checkbox"/> Referred to/date: _____	
10. Is this a planned pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No, describe: _____ *if no, refer to protocol	Is this a wanted pregnancy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Unsure <input type="checkbox"/> No, describe: _____	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: _____
11. Are you thinking about abortion or adoption? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: <input type="checkbox"/> Adoption <input type="checkbox"/> Abortion		
12. How do you feel about being pregnant now? 0-13 Weeks: <input type="checkbox"/> Good <input checked="" type="checkbox"/> Unsure <input type="checkbox"/> Troubled Explain: _____ 14-27 Weeks: <input type="checkbox"/> Good <input checked="" type="checkbox"/> Unsure <input type="checkbox"/> Troubled Explain: _____ 28-40 Weeks: <input type="checkbox"/> Good <input checked="" type="checkbox"/> Unsure <input type="checkbox"/> Troubled Explain: _____	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: _____	
13. How does the father/partner/caregiver of the baby feel about the pregnancy? _____ Your family? _____ Your friends? _____	Intervention/Referral: <input type="checkbox"/> Referred to home visitation program/date: _____ <input type="checkbox"/> Provided information on declaring paternity (per STT PSY: <i>Teen Pregnancy and Parenting</i> – even if client is not a teen) <input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Financial Concerns</i> and <input type="checkbox"/> <i>Legal/Advocacy Concerns</i> <input type="checkbox"/> Referred to social worker/date: _____ <input type="checkbox"/> Referred to/date: _____	

Economic Resources

14. a) Are you currently working or going to school? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, Type of school/work: _____ Hours per week: _____ b) Do you plan to work or go to school while you are pregnant? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No c) Do you plan to return to work/school after baby is born? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	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"/> <i>Keep Safe at Work</i> <input type="checkbox"/> 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: _____
15. Will the father/partner/caregiver provide financial support for you and the baby? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure Other sources of financial help: _____	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: _____

Client Name/ID:

16. Are you receiving any of the following?

	0-13 Weeks		14-27 Weeks		28-40 Weeks		Referral & Date	Intervention: <input type="checkbox"/> Reviewed/discussed STT First Steps: <input type="checkbox"/> <i>Making Successful Referrals</i> and <input type="checkbox"/> <i>Women, Infants and Children (WIC) Supplemental Nutrition Program</i> STT PSY: <input type="checkbox"/> <i>Financial Concerns</i> <input type="checkbox"/> Referred to local WIC Program
	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"/>		

*** If No is checked, no need to write WIC on ICP Summary as long as WIC referral date/Intervention are documented.**

17. a) In the past 12 months, have you worried whether your food would run out before you got money to buy more?
 No Yes, explain: _____

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?
 No Yes, explain: _____

Intervention/Referral:
 Reviewed/discussed STT NUTR: *Getting Healthy Foods* *Tips for Healthy Food Shopping* *You Can Buy Healthy Food on a Budget* *You Can Stretch Your Dollars: Choose These Easy Meals and Snacks*
 Referred to food bank/date: _____
 Referred to/date: _____

Housing

18. What type of housing do you currently live in?
 House Hotel/Motel
 Apartment Farm Worker Camp
 Trailer Park Emergency Shelter
 Public Housing Car
 Other: _____

Any changes in housing?
14-27 Weeks: No Yes, explain: _____
28-40 Weeks: No Yes, explain: _____

19. Members of household (not including client):
Number of adults: _____
Relationship to client: _____
Number of children: _____
Relationship to client: _____

20. Was your house or apartment built before 1978?
 No Yes Unsure
Is there chipping or peeling paint inside or outside the home?
 No Yes Unsure

21. Is your current housing safe and adequate for you and your children?
0-13 Weeks: Yes No, explain: _____
14-27 Weeks: Yes No, explain: _____
28-40 Weeks: Yes No, explain: _____

22. Do any of your children or your partner's children live with someone else?
 N/A
 No
 Yes, explain: _____

Intervention/Referral:
 Reviewed/discussed STT PSY: *Parenting Stress* *New Immigrant Legal/Advocacy Concerns*
 Referred to National Parent Helpline: 1-855-427-2736/date: _____
 Referred to family support/counseling or child abuse prevention program/date: _____
 Referred to social worker/date: _____
 Referred to/date: _____

Client Name/ID:

23. Do you have the following where you live?	0-13 Wks		14-27 Wks		28-40 Wks		
	Yes	No	Yes	No	Yes	No	
	Toilet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Stove/place to cook	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Tub/shower	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Electricity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Refrigerator	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Hot/cold water	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Phone	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Smoke/Carbon Monoxide 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"/>	
24. Do you have a gun in your home? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how is it stored? _____							Intervention/Referral: <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: _____

Transportation

25. Will you have any problems coming to your appointments or attending classes due to transportation, childcare, work, school, or another reason? 0-13 Weeks: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____ 14-27 Weeks: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____ 28-40 Weeks: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____	Intervention/Referral: <input type="checkbox"/> Referred to childcare/date: _____ <input type="checkbox"/> Referred to transportation services/date: _____ <input type="checkbox"/> Referred to/date: _____ <input type="checkbox"/> Provided bus tokens or taxi vouchers/date: _____
26. a) When you ride in a car, do you use seatbelts? <input type="checkbox"/> Always <input checked="" type="checkbox"/> Sometimes <input type="checkbox"/> Never b) Do you know how to use a seat belt when pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE Handout: Pregnant? Steps for a Healthy Baby
27. Do you have a car seat for the new baby? 14-27 Weeks: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28-40 Weeks: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed to STT HE: <input type="checkbox"/> <i>Infant Safety and Health</i> <input checked="" type="checkbox"/> Keep Your Baby Safe and Healthy <input type="checkbox"/> Give referral to free or low-cost car seat program/date: _____ <input type="checkbox"/> Delivery hospital provides car seat prior to discharge:
28. How will you get to the hospital? 14-27 Weeks: _____ <input type="checkbox"/> Unsure <input checked="" type="checkbox"/> No transportation available 28-40 Weeks: _____ <input type="checkbox"/> Unsure <input checked="" type="checkbox"/> No transportation available	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Preterm Labor</i> <input checked="" type="checkbox"/> <i>Hospital Orientation</i> <input type="checkbox"/> If Your Labor Starts Too Early <input type="checkbox"/> Assist client in scheduling tour of delivery hospital/date: _____ <input type="checkbox"/> Provided bus tokens or taxi vouchers/date: _____ <input type="checkbox"/> Referred to childcare/date: _____ <input type="checkbox"/> Referred to transportation services/date: _____

Current Health Practices

29. Do you have a primary care doctor for you and your family? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT Appendix: <i>Introduction to Managed Care</i> <input type="checkbox"/> Referred to/date: _____
30. Do you have a doctor for your baby? 14-27 Weeks: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, who? _____ 28-40 Weeks: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, who? _____	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Infant Safety and Health</i> <input checked="" type="checkbox"/> When Your Newborn Baby is Ill <input type="checkbox"/> Your Baby Needs to be Immunized <input type="checkbox"/> Referred to CHDP provider/date: _____
31. a) Have you been to a dentist in the last 6 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b) Do you have any problems with your teeth, gums, or mouth such as toothaches, bleeding gums, or a bad taste or smell? 0-13 Weeks: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____ 14-27 Weeks: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____ 28-40 Weeks: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE <input type="checkbox"/> <i>Oral Health During Pregnancy</i> <input checked="" type="checkbox"/> Prevent Gum Problems When You Are Pregnant <input checked="" type="checkbox"/> See a Dentist When You Are Pregnant <input type="checkbox"/> Keep Your Teeth and Mouth Healthy! Protect Your Baby Too <input type="checkbox"/> Referred to registered dietitian/date: _____ <input type="checkbox"/> Referred to dentist/date: _____

Client Name/ID:

32. How many total hours do you sleep at night? 0-13 Weeks: _____ 14-27 Weeks: _____ 28-40 Weeks: _____	How many total min/hours do you nap during the day? 0-13 Weeks: _____ 14-27 Weeks: _____ 28-40 Weeks: _____	Intervention/Referral: <input type="checkbox"/> Discuss using extra pillows for joint or back discomfort. To improve relaxation, offer deep breathing, visualization and relaxation techniques/date: _____ <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? _____ <input type="checkbox"/> Referred to social worker/date: _____ <input type="checkbox"/> Referred to/date: _____																																																												
33. Do you exercise? <u>0-13 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, type/frequency: _____ <u>14-27 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, type/frequency: _____ <u>28-40 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, type/frequency: _____		Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Safe Exercise and Lifting</i> _____ <input type="checkbox"/> <i>Exercises To Do When You Are Pregnant</i> _____ <input type="checkbox"/> <i>Stay Active When You Are Pregnant</i> _____ <input type="checkbox"/> <i>Keep Safe When You Exercise</i> _____ <input type="checkbox"/> Referred to provider for discussion of vigorous exercise (lifting heavy weights, running, etc.) during pregnancy/date: _____ <input type="checkbox"/> Referred to exercise or fitness resources that are low-cost/date: _____																																																												
34. Are you currently smoking or using any tobacco products (including hookah or vaping)? <u>0-13 Weeks:</u> <input type="checkbox"/> No <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 <u>14-27 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>28-40 Weeks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, how much per day? _____ Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Tobacco Use</i> _____ <input type="checkbox"/> You Can Quit Smoking _____ <input type="checkbox"/> <i>Secondhand Tobacco Smoke</i> _____ <input type="checkbox"/> Referred to California Smokers' Helpline for free counseling or information about secondhand smoke: 1-800-NO-BUTTS or 1-800-45-NO-FUME (Spanish)/date: _____ <input type="checkbox"/> Referred to smoking cessation program/date: _____ <input type="checkbox"/> Referred to provider for additional counseling on smoking cessation/date: _____																																																												
35. Are you often around other people who smoke cigarettes or any other tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																														
36. Do you use or have exposure to any of the following at home, work, or doing any hobbies? <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th></th> <th>0-13 Weeks</th> <th>14-27 Weeks</th> <th>28-40 Weeks</th> </tr> </thead> <tbody> <tr><td>Products like bleach, ammonia or oven cleaners</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pesticides or chemicals</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cooking with clay pottery</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Jewelry making</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Glue</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Fertilizers</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cat litter box</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pet turtles or reptiles</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Rodents</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Douching</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hot baths or saunas</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>X-Rays</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other: _____</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>None</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			0-13 Weeks	14-27 Weeks	28-40 Weeks	Products like bleach, ammonia or oven cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pesticides or chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cooking with clay pottery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fertilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cat litter box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pet turtles or reptiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Douching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot baths or saunas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Rays	<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 HE: <input type="checkbox"/> <i>Cautions While Pregnant</i> _____ <input type="checkbox"/> <i>Workplace Safety</i> _____ <input type="checkbox"/> Pregnant? Steps for a Healthy Baby _____ <input type="checkbox"/> Keep Safe at Work _____ <input type="checkbox"/> Referred to provider to discuss any harmful exposure to chemicals at home or work/date: _____ <input type="checkbox"/> Referred to MotherToBaby: www.mothersbaby.org or 1-866-626-6847/date: _____
	0-13 Weeks	14-27 Weeks	28-40 Weeks																																																											
Products like bleach, ammonia or oven cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Pesticides or chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Cooking with clay pottery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Jewelry making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Glue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Fertilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Cat litter box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Pet turtles or reptiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Douching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
Hot baths or saunas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																											
X-Rays	<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"/>																																																											
37. At home, where do you store the following?: Vitamins _____ Medications _____ Cleaning Supplies _____ Are these things kept out of the reach of children? <input type="checkbox"/> Yes <input type="checkbox"/> No		Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE Handout: Keep Your New Baby Safe and Healthy																																																												

Client Name/ID:

38. Have either of your parents had a drug or alcohol problem?
 No Yes, describe: _____

Does your partner have a problem with drugs or alcohol?
 No Yes, describe: _____

Have you had a problem with drugs or alcohol in the past?
 No Yes, describe: _____

Intervention/Referral:

Reviewed/discussed STT HE: *Drug and Alcohol Use* _____
 You Can Quit Using Drugs or Alcohol _____ STT PSY: *Perinatal Substance Use/Abuse* _____ *Neonatal Abstinence Syndrome* _____
Your Baby Can't Say "No" _____ **Drugs and Alcohol, When You Want to STOP Using** _____

Notified provider of client's drug/alcohol use/date: _____
 Referred to Alcoholics Anonymous (AA)/date: _____
 Referred to Narcotics Anonymous (NA)/date: _____
 Referred client to Medi-Cal drug treatment facility/date: _____
 Referred to social worker/date: _____
 Referred to Adult Children of Alcoholics, Al-Anon, or Alateen/ date: _____
 Referred to/date: _____

39. 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.

0-13 Weeks: No Yes, describe: _____
14-27 Weeks: No Yes, describe: _____
28-40 Weeks: No Yes, describe: _____

If you use drugs and/or alcohol, are you interested in quitting?
0-13 Weeks: N/A Yes No
14-27 Weeks: N/A Yes No
28-40 Weeks: N/A Yes No

Intervention/Referral:

Reviewed/discussed STT HE: *Drug and Alcohol Use* _____
 You Can Quit Using Drugs or Alcohol _____ STT PSY: *Perinatal Substance Use/Abuse* _____ *Neonatal Abstinence Syndrome* _____
Your Baby Can't Say "No" _____ **Drugs and Alcohol, When You Want to STOP Using** _____

Notified provider of client's drug/alcohol use/date: _____
 Referred to Alcoholics Anonymous (AA)/date: _____
 Referred to Narcotics Anonymous (NA)/date: _____
 Referred client to Medi-Cal drug treatment facility/date: _____
 Referred to social worker/date: _____
 Referred to Adult Children of Alcoholics, Al-Anon, or Alateen/ date: _____
 Referred to/date: _____

40. Are you taking a prenatal vitamin every day?
0-13 Weeks: Yes No
14-27 Weeks: Yes No
28-40 Weeks: Yes No

Intervention/Referral:

Prenatal vitamins prescribed by provider/date: _____
 Encouraged client to continue taking prenatal vitamins (and any other supplements recommended by provider)/date: _____
 Notified provider of any medication/supplement use to ensure safety during pregnancy/date: _____
 Reviewed/discussed STT NUTR: *Prenatal Supplements: Vitamins, Minerals, and Other Supplements* _____ **Take Prenatal Vitamins and Minerals** _____ **If You Need Iron Pills** _____ **You May Need Extra Calcium** _____
 Referred to MotherToBaby: www.mothertobaby.org or 1-866-626-6847/date: _____
 Referred to/date: _____

41. Are you taking any prescription, over-the-counter, or herbal medications? Examples: iron, pain medication, antidepressants, antacids, allergy medication, laxatives, or herbal remedies like yerba buena, ginseng, or manzanilla?

0-13 Weeks: No Yes: _____
14-27 Weeks: No Yes: _____
28-40 Weeks: No Yes: _____

Pregnancy Care

42. Besides having a healthy baby, what are your goals for this pregnancy?

43. Do you plan to have someone with you:
During labor?
14-27 Weeks: No Yes: _____
28-40 Weeks: No Yes: _____

When you first come home with the baby?
14-27 Weeks: No Yes: _____
28-40 Weeks: No Yes: _____

Intervention/Referral:

Referred to/for: _____

Intervention/Referral:

Refer to childbirth classes/date: _____
 Refer to home visitation program/date: _____
 Refer to Medi-Cal doula services: _____
 Referred to/date: _____

44. If you had a baby before, where was it delivered?
 N/A **Clinic**
 Hospital **Home**
 Other: _____

Did you or the baby have any problems?
 No Yes, explain: _____

Intervention/Referral:

Notified provider of prior complications: _____
 Provided information about the delivery hospital, including tours, registration, parking, and how to get there from her home

Client Name/ID:

45. Have you ever lost any children? (miscarriage, stillbirth, SIDS, immigration, custody, etc.)

No

Yes, please explain: _____

Intervention/Referral:

Reviewed/discussed STT PSY: *Perinatal Loss* **Loss of Your Baby**
 Ways to Remember Your Baby

Referred to grief and loss resource: _____

Referred to First Candle grief support line at: 1-800-221-7437

Discussed Return to Zero materials (available at www.rtzhope.org)

Referred to social worker or mental health/date: _____

Referred to/date: _____

46. Do you have any questions about any prenatal tests or procedures?

0-13 Weeks: No Yes: _____

14-27 Weeks: No Yes: _____

28-40 Weeks: No Yes: _____

Intervention/Referral:

Reviewed/discussed STT Appendix: *Prenatal Laboratory and Diagnostic Tests* _____

Answered questions/concerns: _____

Referred to provider for/date: _____

47. Have you experienced any of these discomforts during your pregnancy?

	0-13 Weeks	14-27 Weeks	28-40 Weeks
Edema (Swelling in hands/feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramping or contractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Intervention/Referral:

Edema:

Notified provider of sudden weight gain or swelling of the face/date: _____

Notified provider of higher than normal blood pressure/date: _____

Encouraged client to elevate her feet, avoid eating salty foods, and drink at least 8 glasses of water a day.

Diarrhea:

Notified provider of diarrhea symptoms/date: _____

Referred to/for: _____

Reviewed/discussed STT NUTR: *Lactose Intolerance* **Do You Have Trouble with Milk Foods?** _____ **Foods Rich in Calcium** _____

Constipation:

Reviewed/discussed STT NUTR: *Constipation* _____ **Constipation: What You Can Do** _____ **Constipation: What Products You Can and Cannot Use** _____

Notified provider of constipation symptoms/date: _____

Nausea/Vomiting:

Notified provider of nausea/vomiting symptoms/date: _____

Reviewed/discussed STT NUTR: *Nausea & Vomiting* _____ **Nausea: Tips that Help** _____ **Nausea: What To Do When You Vomit** _____ **Nausea: Choose These Foods** _____

Leg cramps & Hemorrhoids:

Education on _____ was provided/date: _____

Notified provider of _____ symptoms/date: _____

Heartburn:

Reviewed/discussed STT NUTR: *Heartburn* _____ **Heartburn: What You Can Do** _____ **Heartburn: Should You Use Antacids?** _____

Varicose veins & Headaches:

Education on _____ was provided/date: _____

Notified provider of _____ symptoms/date: _____

Backaches, Vaginal Bleeding, & Abdominal cramping/contractions:

Reviewed/discussed STT HE: *Preterm Labor* _____ **If Your Labor Starts Too Early** _____ **Safe Exercise & Lifting** _____ **Exercises To Do When You Are Pregnant** _____

Notified provider of _____ symptoms/date: _____

Additional education (describe in progress note if more space needed): _____

Client Name/ID: _____

<p>48. Does the doctor say there are any problems with this pregnancy?</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 the provider or health educator for: _____</p> <p><input type="checkbox"/> Referred to a registered dietitian/date: _____</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> _____</p> <p><input type="checkbox"/> <i>Getting Ready for Multiples</i> _____</p> <p><input type="checkbox"/> Referred to a Prenatal Diagnostic Center (PDC)/date: _____</p> <p><input type="checkbox"/> Referred to/date: _____</p>
<p>49. 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>50. 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</p> <p><input type="checkbox"/> Doula <input type="checkbox"/> No one</p> <p><input type="checkbox"/> Other: _____</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. What are the most important things they have told you? Describe:</p>	
<p>52. 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"/> Referred to provider for: _____</p>
<p>53. Would you like to become pregnant in the next 18 months?</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"/> 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>54. 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>55. Do you plan to use birth control after this pregnancy?</p> <p>14-27 Weeks: <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>28-40 Weeks: <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:

56. These questions help us identify any risk factors for diseases like chlamydia, gonorrhea, genital herpes, hepatitis B & C, syphilis, 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"/> STIs (<i>Sexually Transmitted Infections</i>) _____ <input type="checkbox"/> HIV and Pregnancy _____ <input type="checkbox"/> What You Should Know About STDs _____ <input type="checkbox"/> What You Should Know About HIV _____ <input type="checkbox"/> You Can Protect Yourself and Your Baby from STDs _____	
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	_____	
57. 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

58. 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	
59. 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 partner/father of the baby, friend, parent, or close relative	
60. 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	
61. 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"/> Pregnant? Steps for a Healthy Baby <input type="checkbox"/> Keep Your New Baby Safe and Healthy <input type="checkbox"/> Referred to home visitation program/date: _____ <input type="checkbox"/> Referred to Medi-Cal doula services/date: _____ <input type="checkbox"/> Referred to group education classes/date: _____	

62. 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"/>		
Chest/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"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Client Name/ID:

62a. Do you plan on receiving Tdap vaccine in your 3 rd trimester?	
<u>14-27 Weeks:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed SST HE: <i>Immunizations and Pregnancy</i> <input type="checkbox"/> Provided education on the benefits of Tdap between 27-36 weeks in the 3 rd trimester
<u>28-40 Weeks:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed SST HE: <i>Immunizations and Pregnancy</i> <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
62b. Do you plan on receiving the influenza vaccine during pregnancy?	
<u>0-13 Weeks:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <u>14-27 Weeks:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <u>28-40 Weeks:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Intervention/Referral: <input type="checkbox"/> Provided additional education on the benefits of the influenza vaccine during pregnancy <input type="checkbox"/> Referred for influenza vaccine/date: _____ <input type="checkbox"/> Influenza vaccine administered/date: _____ <input type="checkbox"/> Client plans to receive influenza vaccine after delivery <input type="checkbox"/> Client declines influenza vaccine <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> 3 rd Trimester
63. Is there anything else that you would like to learn? _____ _____	Intervention/Referral: <input type="checkbox"/> Provided education on: _____ _____

Nutrition: Anthropometric

<p>64. Weight gain in last pregnancy: _____ lbs. <input type="checkbox"/> Unknown <input type="checkbox"/> N/A</p> <p>65. Pre-pregnant weight: _____ lbs. Height: _____</p> <p>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</p> <p><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</p>	<p>Intervention/Referral: <input type="checkbox"/> Refer to STT NUTR: <i>Weight Gain During Pregnancy</i>- Section: “<i>How to Determine Gestational Weight Gain Goals and Assess Weight Gain</i>” <input type="checkbox"/> Review/discussed Handout: <i>MyPlate for Pregnant and New Parents including Breastfeeding and Tips to Gain Weight</i></p> <p><u>Underweight:</u> <input type="checkbox"/> Reviewed/discussed STT NUTR: <i>Weight Gain During Pregnancy</i> – Section: “<i>Underweight</i>” <input type="checkbox"/> Review/discussed Handout: <i>MyPlate for Pregnant and New Parents including Breastfeeding and Tips to Gain Weight</i> <input type="checkbox"/> Recommended regular meals and larger portions <input type="checkbox"/> Discussed weight gain goal per month = 3-4 lbs for single pregnancy</p> <p><u>Overweight:</u> <input type="checkbox"/> Reviewed/discussed STT NUTR: <i>Weight Gain During Pregnancy</i> – Section: “<i>Overweight</i>” <input type="checkbox"/> Reviewed/discussed STT Nutrition handout: <i>MyPlate for Pregnant and New Parents including Breastfeeding</i> <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 16th week for single pregnancy</p> <p><u>Obese:</u> <input type="checkbox"/> Reviewed/discussed STT NUTR: <i>Weight Gain During Pregnancy</i> – Section: “<i>Obese</i>” <input type="checkbox"/> Review and discuss STT Nutrition handout: <i>MyPlate for Pregnant and New Parents including Breastfeeding</i> <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 16th week for single pregnancy</p>
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Client Name/ID:

66. Net Weight Gain

0-13 Weeks: _____ lbs.

- Adequate Inadequate
 Excessive Weight Loss

14-27 Weeks: _____ lbs.

- Adequate Inadequate
 Excessive Weight Loss

28-40 Weeks: _____ lbs.

- Adequate Inadequate
 Excessive Weight Loss

Table 2: RECOMMENDATIONS FOR TOTAL AND RATE OF WEIGHT GAIN DURING PREGNANCY BASED ON PRE-PREGNANCY BMI¹

Pre-pregnancy BMI Category	BMI	Total Weight Gain Range (lbs)	Rates of Second and Third Trimester Weight Gain*
Underweight	<18.5	28-40	1-1.3
Normal Weight	18.5-24.9	25-35	0.8-1.0
Overweight	25.0-29.9	15-25	0.5-0.7
Obese	≥30.0	11-20	0.4-0.6

* Calculations assume a 0.5-2.0 kg (1.1-4.4 lbs) weight gain the first trimester (based on Siega-Riz et al, 1994; Abrams et al, 1995; Carmichael et al., 1997)

¹ Institute of Medicine. *Nutrition During Pregnancy, Part 1, Weight Gain*. National Academy Press: Washington, DC, 1990.

Example

The overweight woman in the previous example should gain a total of 15 to 25 pounds and 0.5 to 0.7 pounds per week after the first trimester.

Intervention/Referral

- Determined client's recommended net weight gain per STT NUTR: *Weight Gain During Pregnancy*
- Provided education about age-related nutritional needs/date: _____
- Referred to registered dietitian for/date: _____

Excessive Weight Gain:

- Discussed the risk of larger baby and delivery complications/date: _____
- If excessive weight gain, reviewed/discussed STT NUTR: *Tips to Slow Weight Gain* _____
- Recommended low fat foods, more water, and less sugary drinks like soda and juice

Inadequate Weight Gain:

- Discussed risk of preterm/low birth weight baby.
- If inadequate weight gain (or if weight loss), reviewed/discussed STT NUTR: *Tips to Gain Weight* _____
- Recommended more frequent, calorie-dense meals

Weight Loss:

- Notified provider/date: _____
- Discussed risk of preterm/low birth weight baby.
- Reviewed/discussed STT NUTR: *Tips to Gain Weight*
- Recommend more frequent, calorie-dense meals
- Discussed risks associated with weight gain/loss: _____

Nutrition: Biochemical

Client Name/ID: _____

<p>67. Consult with provider if there are abnormal lab values and discuss treatment prescribed.</p> <p><u>0-13 Weeks:</u> Date blood drawn: _____ Hgb: _____ (<11g/L) Hct: _____ (<33%) Glucose: _____ MCV: _____</p> <p><u>14-27 Weeks:</u> Date blood drawn: _____ Hgb: _____ (<10.5g/L) Hct: _____ (<32%) Glucose: _____ MCV: _____</p> <p><u>28-40 Weeks:</u> Date blood drawn: _____ Hgb: _____ (<11g/L) Hct: _____ (<33%) Glucose: _____ MCV: _____</p> <p>-----</p> <p>OGTT</p> <p><u>Initial Prenatal Visit (if applicable)</u> Date: _____ Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 Hr: _____ <input type="checkbox"/> N/A</p> <p><u>24-28 weeks</u> Date: _____ Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 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"/> <i>Get the Iron You Need</i> _____ <input type="checkbox"/> <i>Iron Tips</i> _____ <input type="checkbox"/> <i>Iron Tips – Take Two!</i> _____ <input type="checkbox"/> <i>My Action Plan for Iron</i> _____</p> <p><input type="checkbox"/> For Folic Acid Deficiency Anemia, reviewed/discussed: STT NUTR: <input type="checkbox"/> <i>Get the Folic Acid You Need</i> _____ <input type="checkbox"/> <i>Folic Acid: Every Woman, Every Day</i> _____</p> <p><input type="checkbox"/> For Vitamin B₁₂ Deficiency Anemia: reviewed/discussed STT NUTR: <input type="checkbox"/> Vegetarian Eating _____ <input type="checkbox"/> <i>When You Are Vegetarian: What You Need to Know</i> _____ <input type="checkbox"/> <i>Vitamin B₁₂ is Important</i> _____</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"/> <i>MyPlate for People with Gestational Diabetes</i> _____ <input type="checkbox"/> <i>If You Have Diabetes While You Are Pregnant: Questions You May Have</i> _____ <input type="checkbox"/> <i>If You Have Diabetes While You Are Pregnant: Ways to Lower Your Stress</i> _____</p> <p><input type="checkbox"/> Referred to diabetes specialist/date: _____</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p>

Client Name/ID:

<p>71. Hypertension</p> <p>Pre-pregnancy: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 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 <u>14-27 Weeks:</u> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <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, preeclampsia) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____</p> <p>73. Any risk factors indicating the use of Aspirin? (have the patient complete the <i>Should I do Aspirin?</i> pocket card) Notify provider of any "Yes" answers <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____</p> <p>74. 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: _____ <u>14-27 Weeks:</u> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____ <u>28-40 Weeks:</u> <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> <hr/> <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.mothersbaby.org /date: _____</p> <p><input type="checkbox"/> Discussed whether exercise is safe or not.</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p> <p><input type="checkbox"/> Referred to provider/date: _____</p>
<p>75. Pregnancy interval < 18 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>76. High parity? (≥ 4 births) <input checked="" type="checkbox"/> Yes <input 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>77. Multiple gestation? <input checked="" type="checkbox"/> Yes <input 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 checked="" type="checkbox"/> <i>Getting Ready for Multiples</i> <input checked="" type="checkbox"/> <i>If Your Labor Starts Too Early</i></p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p>
<p>78. Are you currently chest/breastfeeding? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Referred to provider (especially if history of miscarriage or preterm labor and she is currently chest/breastfeeding while pregnant)</p> <p><input type="checkbox"/> Reviewed/discussed STT NUTR: <i>MyPlate for Pregnant and New Parents including Breastfeeding</i> and 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>79. 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: _____ <u>14-27 Weeks:</u> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____ <u>28-40 Weeks:</u> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed client's pregnancy weight, BMI, and weight gain goal for each month. Check to see if they are meeting the weight gain goal according to their BMI</p> <p><input type="checkbox"/> Reviewed/discussed handout: <i>MyPlate for Pregnant and New Parents including Breastfeeding</i> _____</p> <p><input type="checkbox"/> Reviewed/discussed lacking food groups and proper proportions on a 10-inch healthy plate if client ate less or gained insufficient weight.</p> <p><input type="checkbox"/> Reviewed/discussed nutritious food groups and proper proportions on a 10-inch healthy plate if client gained excess weight or ate too much of core nutrients.</p> <p><input type="checkbox"/> Referred to/date: _____</p>
<p>80. Do you ever crave/eat any of the following:</p> <p><input checked="" 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 checked="" type="checkbox"/> <i>MyPlate for Pregnant and New Parents including Breastfeeding</i></p> <p><input type="checkbox"/> Referred to provider/date: _____</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p>

Client Name/ID:

<p>81. a) Number of meals/day: _____</p> <p>b) Meals often skipped? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Number of snacks/day: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed handout: MyPlate for Pregnant and New Parents including Breastfeeding and discussed the 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>82. 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>
<p>83. Are you on any special diet (medical diet, personal diet, etc.)?</p> <p><u>0-13 Weeks:</u> <input type="checkbox"/> Yes, explain: _____ <input type="checkbox"/> No</p> <p><u>14-27 Weeks:</u> <input type="checkbox"/> Yes, explain: _____ <input type="checkbox"/> No</p> <p><u>28-40 Weeks:</u> <input type="checkbox"/> Yes, explain: _____ <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 handout: MyPlate for Pregnant and New Parents including Breastfeeding _____ (<i>emphasize proportions of food groups on a 10-inch plate recommended for pregnancy</i>)</p> <p><input type="checkbox"/> Referred to provider/date: _____</p> <p><input type="checkbox"/> Referred to registered dietitian/date: _____</p>
<p>84. Any food allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p>Any foods/beverages you avoid? <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>85. Are you vegetarian or vegan? <input type="checkbox"/> No <input type="checkbox"/> Yes: Do you eat: <input type="checkbox"/> Milk Products <input type="checkbox"/> Eggs <input type="checkbox"/> Nuts <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>86. <u>0-13 Weeks:</u></p> <p>a) How do you plan to feed your baby? <input type="checkbox"/> Chest/Breastfeed <input type="checkbox"/> Formula <input type="checkbox"/> Chest/Breastfeed + Formula <input type="checkbox"/> Undecided</p> <p>b) Have you ever chest/breastfed or tried to chest/breastfeed? <input type="checkbox"/> If yes, for how long? _____ <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>c) Did you chest/breastfeed for as long as you wanted? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain: _____ <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><input type="checkbox"/> 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>

Client Name/ID:

<p><u>14-27 Weeks:</u></p> <p>a) What do you think about breastfeeding your new baby?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Not interested <input type="checkbox"/> Thinking about it <input type="checkbox"/> Wants to <input type="checkbox"/> Definitely will <input type="checkbox"/> Other: _____ <p>b) What questions do you have about feeding your baby?</p> <p>_____</p>	<p>Intervention/Referral:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Answered chest/breastfeeding questions/concerns <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> <input type="checkbox"/> Referred to WIC/date: _____ <input type="checkbox"/> Referred to chest/breastfeeding education classes: _____ <input type="checkbox"/> Referred to/date: _____
<p><u>28-40 Weeks:</u></p> <p>a) How do you plan to feed your baby during the first month?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest/Breastfeed <input type="checkbox"/> Formula <input type="checkbox"/> Chest/Breastfeed + Formula <p>b) If you are going to chest/breastfeed, who can you go to for chest/breastfeeding help?</p> <p>_____</p> <p>c) What questions do you have about feeding your baby?</p> <p>_____</p>	<p>Intervention/Referral:</p> <ul style="list-style-type: none"> <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> <input type="checkbox"/> Provided education on safe formula preparation and feeding <input type="checkbox"/> Discussed how supplementing with formula can decrease milk production <input type="checkbox"/> Referred to WIC/date: _____ <input type="checkbox"/> Referred to breastfeeding education classes/date: _____ <input type="checkbox"/> Referred to/date: _____
<p>87. Diet intake assessment completed:</p>	
<p><u>0-13 Weeks:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Perinatal Food Group Recall (PFGR) <input type="checkbox"/> Perinatal Food Group Recall for Gestational Diabetes (PFGR) <input type="checkbox"/> 24-hour Perinatal Dietary Recall <input type="checkbox"/> Perinatal Food Frequency Questionnaire (PFFQ) <p>Diet adequate as assessed?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Intervention/Referral:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reviewed/discussed Handout: <input type="checkbox"/> <i>MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding</i> <input type="checkbox"/> Reviewed/discussed Handout: <input type="checkbox"/> <i>MyPlate for People with Gestational Diabetes/MyPlan for People with Gestational Diabetes</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: _____
<p><u>14-27 Weeks:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Perinatal Food Group Recall (PFGR) <input type="checkbox"/> Perinatal Food Group Recall for Gestational Diabetes (PFGR) <input type="checkbox"/> 24-hour Perinatal Dietary Recall <input type="checkbox"/> Perinatal Food Frequency Questionnaire (PFFQ) <p>Diet adequate as assessed?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Intervention/Referral:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reviewed/discussed Handout: <input type="checkbox"/> <i>MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding</i> <input type="checkbox"/> Reviewed/discussed Handout: <input type="checkbox"/> <i>MyPlate for People with Gestational Diabetes/MyPlan for People with Gestational Diabetes</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: _____
<p><u>28-40 Weeks:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Perinatal Food Group Recall (PFGR) <input type="checkbox"/> Perinatal Food Group Recall for Gestational Diabetes (PFGR) <input type="checkbox"/> 24-hour Perinatal Dietary Recall <input type="checkbox"/> Perinatal Food Frequency Questionnaire (PFFQ) <p>Diet adequate as assessed?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Intervention/Referral -</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reviewed/discussed Handout: <input type="checkbox"/> <i>MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding</i> <input type="checkbox"/> Reviewed/discussed Handout: <input type="checkbox"/> <i>MyPlate for People with Gestational Diabetes/MyPlan for People with Gestational Diabetes</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: _____

Client Name/ID:

Coping Skills

88. Are you currently having problems/concerns with any of the following?	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:

- Reviewed/discussed: STT PSY: *Financial Concerns* _____
- Legal/Advocacy Concerns* _____ *New Immigrant* _____
- Emotional or Mental Health Concerns* _____
- Referred to legal assistance (free or low cost): _____
- Referred to social worker/date: _____
- Referred to home visitation program/date: _____
- Referred to/date: _____

89. What things in your life do you feel good about?

90. What things in your life would you like to change?

91. Who do you turn to for emotional support?
 FOB/partner Family member Friend
 Doula Other: _____

92. What do you do when you are upset?

93. What do you do when you and your partner have disagreements?

Intervention/Referral:

- Reviewed/discussed: _____
- Referred to provider/date: _____
- Referred to social worker/date: _____
- Referred to/date: _____

94. Perinatal Depression Screening (use PHQ-9)

0-13 Weeks:

Patient Health Questionnaire -9 (PHQ-9)

Total Score:

- 0-4 (None/Minimal)
- 5-9 (Mild)
- 10-14 (Moderate)
- 15-19 (Moderate Severe)
- 20-27 (Severe)

Intervention/Referral:

- Notified provider of score of 5+ higher (PHQ-9)
- Reviewed/discussed STT PSY: *Emotional/Mental Health Concerns* *Depression* **How Bad Are Your Blues?** _____
- Provided handout: _____
- Encouraged client to inform provider if symptoms worsen
- Referred to Postpartum Support International at: 1-800-944-4773
- Referred to mental health clinic/date: _____
- Referred to social worker/date: _____
- Referred to DMH ACCESS hotline 1-800-854-7771: Date: _____
- Referred to Maternal Mental Health Hotline at: 1-833-TLC-MAMA (call/text)

Client Name/ID: _____

<p><u>14-27 Weeks:</u></p> <p><u>Patient Health Questionnaire -9 (PHQ-9)</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 score of 5+ higher (PHQ-9)</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"/> Provided handout: _____</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 social worker or mental health clinic: Date: _____</p> <p><input type="checkbox"/> Referred to DMH ACCESS hotline 1-800-854-7771: Date: _____</p> <p><input type="checkbox"/> Referred to Maternal Mental Health Hotline at: 1-833-TLC-MAMA (call/text)</p>
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<p><u>28-40 Weeks:</u></p> <p><u>Patient Health Questionnaire -9 (PHQ-9)</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 score of 5+ higher (PHQ-9)</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"/> Provided handout: _____</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 social worker or mental health clinic: Date: _____</p> <p><input type="checkbox"/> Referred to DMH ACCESS hotline 1-800-854-7771: Date: _____</p> <p><input type="checkbox"/> Referred to Maternal Mental Health Hotline at: 1-833-TLC-MAMA (call/text)</p>
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<p>95. 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 style="padding-left: 40px;">o</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>
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<p>96. 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>
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<p>97. Have you ever been emotionally or physically abused by your partner or someone important to you?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____</p> <p>98. Do you ever feel afraid of your partner?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____</p> <p>99. Within the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, by whom? _____</p> <p style="padding-left: 40px;">How many times? _____</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"/> <i>Cycle of Violence</i> <input type="checkbox"/> <i>Safety When Preparing to Leave</i> <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>
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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:

