COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)
TRAINING*: "THE BASICS"*

AGENDA

Intended Audience: CPHWs providing direct perinatal care.

8:30 AM - 9:00 AM **Registration**

9:00 AM - 9:30 AM **Welcome/Self Introductions**

9:30 AM - 12:00 Noon ***CPSP CYCLE*: Overview of CPSP Components**

A. Client Orientation
B. Initial Combined Assessment/ Trimester Reassessments
C. Problems/Issues List
D. Individualized Care Plan
E. Case Coordination
F. Postpartum Assessment

12:00 Noon- 1:00 PM **Lunch**

1:00 PM - 1:30 PM **Development of the ICP**

1:30 PM - 2:00 PM **Review of CPSP Tools and Steps to Take (STT)**

- Protocols
- Steps To Take Guidelines
- Relationship of all CPSP tools

2:00 PM - 2:30 PM **Wrap Up: Questions and Answers**
Evaluation

"CPSP The Basics"

Goals and Objectives

Goals: To increase the knowledge and skills of CPSP Practitioners in providing effective and efficient CPSP services to better meet the needs of clients and improve overall birth outcomes.

Objectives: At the end of this training participants will be able to:

1. Understand Medi-Cal Managed Care Assessment/Reassessment tool, Individualized Care plan Protocols.

2. Understand how to use Steps To Take, CPSP Guidelines for Enhanced Health Education (HE) Nutrition (N), and Psychosocial (P/S) Service, as an important component of protocol development.

3. List the components of the CPSP cycle.

4. Understand how to develop an individualized care plan as part of the initial combined assessment.

5. Understand how to update an individualized care plan

6. Describe the role of a case coordinator.

7. Develop effective interventions based on assessment & individualized care plans.

8. Describe the role of discipline-specific (HE, N, P/S) consultants, and how to make appropriate referrals.

9. Correctly document all CPSP services provided.

BONUSES

EARLY ENTRY INTO CARE (Z1032-ZL) - If the patient receives her initial pregnancy-related exam within 16 weeks LMP (anytime prior to 17 weeks), add modifier -ZL to the Initial Pregnancy-Related exam code Z1032 and add $56.63 to your "usual and customary fees" for this service. Maximum allowance for Z1032-ZL is $182.94 ($126.31 + $56.63).

Billing ZL Modifier when done by Non-Physician Medical Practitioner (multiple Modifier):

CNM bills YR: ZL + SB
NP bills YT: ZL + SA
PA bills YU: ZL + AN

10TH ANTEPARTUM VISIT (Z1036) - may be billed one time only when the 10th antepartum visit is provided. Medi-Cal reimburses non-CPSP providers for the initial prenatal visit and 8 antepartum visits (9 visits total). CPSP providers are able to bill for one additional visit. Reimbursement is $113.26.

CPSP SUPPORT SERVICES

Support services (health education, nutrition, and psychosocial) are billed in 15 minute units. A minimum of 8 minutes of service must be provided in order to bill.

UNITS	TIME (Minutes)	RANGE (Minutes)
1	15	8-22
2	30	23-37
3	45	38-52
4	60	53-67

Formula for determining time range is as follows:

Range = Time ± 7 minutes

Example: 3 units = 45 minutes (3 x 15 min.)
45 minus 7 = 38 minutes
45 plus 7 = 52 minutes
Range for 3 units = 38-52 minutes

Summary of CPSP Medi-Cal Billing

Name: _____ D.O.B.: _____ MR#: _____

CPSP Patient Billing	Billing Code	Number of Units Used (1 Unit = 15 Minutes) *Please Initial and Date Each Unit Used per Visit*
Obstetrical (# Visits)		
Initial Antepartum	Z1032	
Early Entry Bonus (16 wks LMP)	ZL	Modifier for use with Z1032 only
Antepartum Visits	Z1034	1 2 3 4 5 6 7 8
10th Antepartum Visit	Z1036	After initial visit and 8 antepartums
Postpartum	Z1038	
Prenatal Vitamins (# 300)	Z6210	
CPSP Services		
Initial Comp Assess.	Z6500*	* All 3 completed within
1. Health Education 30 Min - Indiv	*Date:*	4 weeks of Initial Prenatal Visit (Z1032)
2. Nutrition 30 Min - Indiv	*Date:*	
3. Psychosocial 30 Min - Indiv	*Date:*	
Nutrition		
Initial Assessment - Indiv 30 min	Z6200	Don't use if Z6500 billed
Add'l Init Assess - Indiv 1.5 hrs	Z6202	1 2 3 4 5 6
F/U Interven/Reassess - Indiv 2 hrs	Z6204	1 2 3 4 5 6 7 8
F/U Intervention - Group 3 hrs	Z6206	1 2 3 4 5 6 7 8 9 10 11 12
Postpartum - Indiv 1hr	Z6208	1 2 3 4
Psychosocial		
Initial Assessment - Indiv 30 min	Z6300	Don't use if Z6500 billed
Add'l Init Assess - Indiv 1.5 hrs	Z6302	1 2 3 4 5 6
F/U Interven/Reassess - Indiv 3 hrs	Z6304	1 2 3 4 5 6 7 8 9 10 11 12
F/U Intervention - Group 4hrs	Z6306	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
Postpartum - Indiv 1.5 hrs	Z6308	1 2 3 4 5 6
Health Education		
Client Orientation - Indiv 2 hrs	Z6400	1 2 3 4 5 6 7 8
Initial Assessment - Indiv 30 min	Z6402	Don't use if Z6500 billed
Additional Init Assess - Indiv 2 hrs	Z6404	1 2 3 4 5 6 7 8
F/U Interven/Reassess - Indiv 2 hrs	Z6406	1 2 3 4 5 6 7 8
F/U Ed Assess/Interv Group 2 hrs	Z6408	1 2 3 4 5 6 7 8
Postpartum - Indiv 1 hr	Z6414	1 2 3 4
Perinatal Education - Indiv 4hrs	Z6410	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
Perinatal Education - Group 18 hrs	Z6412	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72

COMPREHENSIVE PERINATAL SERVICES PROGRAM
Service Codes and Reimbursement Schedule

The following are the Comprehensive Perinatal Provider service codes effective August 1, 2000 for Nutrition, Health Education, and Psychosocial services.

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
Z6500 [2]	Initial Comprehensive Nutrition, Psychosocial, and Health Education Assessments and Development of Care Plan within 4 weeks of entry into care [3], Individual, first 30 minutes of each Assessment (90 minutes total), including ongoing coordination of care. Initial Pregnancy-related exam (Z1032) must also be completed within this 4-week period.	Initial CPSP Assessment completed within 4 weeks of Initial Prenatal Exam (Z1032). This 90 minutes is for Health Educ., Nutrition, and Psychosocial initial assessment time only - does not include Client Orientation.	1	$135.83	$135.83
NUTRITION CODES					
Z6200	Initial Nutrition Assessment and Development of Care Plan, Individual, first 30 minutes.	For first 30 minutes of Initial Nutrition Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	$16.83	$16.83
Z6202	Initial Nutrition Assessment and development of Care Plan, Individual, each Subsequent 15 minutes (Maximum of 1 2 hours)	1) Time spent doing initial assessment exceeded 30 minutes in nutrition component (either Z6500 or Z6200 used); 2) AEntirely new problem@ diagnosed later in pregnancy requiring a new nutrition assessment, e.g. gestational diabetes.	6	$8.41	$50.46
Z6204	Follow-up Antepartum Nutrition Assessment, Treatment, and/or Intervention, Individual, each 15 minutes	Trimester reassessments; antepartum counseling, such as by RD consultant.	8	$8.41	$67.28

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
	(Maximum of 2 hours)				
Z6206	Follow-up Antepartum Nutrition Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes (Maximum of 3 hours)	Nutrition information provided in a group class.	12	$2.81	$33.72
Z6208	Postpartum Nutrition Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 1 hour)	1) Postpartum nutrition assessment; 2) Postpartum nutrition intervention, e.g. assistance with breastfeeding	4	$8.41	$33.64
Z6210	Prenatal Vitamin-Mineral Supplement, 300 Day Supply	Prenatal vitamins dispensed by office; cannot bill until all 300 have been dispensed	1	$39.96	$39.96
PSYCHOSOCIAL CODES					
Z6300	Initial Psychosocial Assessment and Development of Care Plan, Individual, first 30 minutes	For first 30 minutes of Initial Psychosocial Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	$16.83	$16.83
Z6302	Initial Psychosocial Assessment and Development of Care Plan, Individual, each subsequent 15 minutes (Maximum of 1 2 hours)	1) Time spent doing initial assessment exceeded 30 minutes in psychosocial component (either Z6500 or Z6300 used); 2) AEntirely new problem@ diagnosed later in pregnancy requiring a new psychosocial assessment, e.g. domestic violence.	6	$8.41	$50.46
Z6304	Follow-up Antepartum Psychosocial Assessment, Treatment, and/or Intervention, Individual, each 15 minutes (Maximum of 3 hours)	Trimester reassessment; antepartum counseling or other intervention, such as by social work consultant.	12	$8.41	$100.92
Z6306	Follow-up Antepartum Psychosocial	Psychosocial information provided	16	$2.81	$44.96

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
	Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes (Maximum of 4 hours)	in a group class.			
Z6308	Postpartum Psychosocial Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 12 hours)	1) Postpartum psychosocial assessment; 2) Postpartum psychosocial intervention, e.g. postpartum depression	6	$8.41	$50.46
		HEALTH EDUCATION CODES			
Z6400	Client Orientation, Individual, each 15 minutes (Maximum of 2 hours)	Initial individual orientation (required); orientation required during pregnancy, e.g. when patient is referred to hospital for non-stress test.	8	$8.41	$67.28
Z6402	Initial Health Education Assessment and Development of Care Plan, Individual, first 30 minutes	For first 30 minutes of Initial Health Education Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	$16.83	$16.83
Z6404	Initial Health Education Assessment and Development of Care Plan, Individual, each subsequent 15 minutes (Maximum of 2 hours)	1) Time spent doing initial assessment exceeded 30 minutes in health education component (either Z6500 or Z6402 used); 2) AEntirely new problem@ diagnosed later in pregnancy requiring a new health education assessment.	8	$8.41	$67.28
Z6406	Follow-up Antepartum Health Education Assessment, Treatment, and/or Intervention, Individual, each 15 minutes (Maximum of 2 hours)	Trimester reassessment; antepartum counseling or other intervention, such as by health education consultant.	8	$8.41	$67.28
Z6408	Follow-up Antepartum Health Education	Health education provided in a	8	$2.81	$22.48

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
	Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes (Maximum of 2 hours)	group class.			
Z6414	Postpartum Health Education Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 1 hour)	1) Postpartum health education assessment; 2) Postpartum health education intervention.	4	$8.41	$33.64
PERINATAL EDUCATION CODES (Can be used antepartum or postpartum)					
Z6410	Perinatal Education, Individual, each 15 minutes (Maximum of 4 hours)	Individual education provided prenatally or postpartum.	16	$8.41	$134.56
Z6412	Perinatal Education, Group, per patient, each 15 minutes (Maximum 4 hours/day,18 hours/pregnancy)	Group education, e.g. childbirth education (Lamaze)	72	$2.81	$202.32
CPSP OB BONUSES					
Z1032-ZL	Initial Comprehensive Pregnancy-related office visit performed within 16 weeks of LMP	Initial prenatal exam done prior to 17 weeks LMP. *If non-physician practitioner (NP, PA, CNM) does exam, see M/C Provider Manual for appropriate modifier.*	1	$56.63	$56.63
Z1036	Tenth Antepartum Office Visit	One time only when 10th antepartum visit performed.	1	$113.26	$113.26

[1] Additional reimbursement is subject to prior approval using a Medi-Cal Treatment Authorization Request (TAR).
[2] If Z6500 is used, codes Z6200, Z6300, and Z6402 cannot be used because the first 30 minutes of each assessment is already included in Z6500.
However, additional initial assessment time can be billed under codes Z6202, Z6302, or Z6404.

[3] Entry into care is the time of the first billable pregnancy-related office visit or initial support service assessment.

CalLearn Sanctions

If you don't turn in your report card on time or if you are not making "satisfactory progress," *you may get sanctioned*!

You'll get a 10 day notice if there is a problem. The worker also needs to try to call or see you.

√ Turn in your report card or ask your worker to find that you had "good cause" in this 10 day time.

Good cause is when:

- You were temporarily sick.
- You had to go to court or were incarcerated.
- Bad weather kept you from going to school.
- You had no transportation.
- You don't want major medical services needed to do school.
- Child care problems (not reasonably available during school, child ineligible for Cal-Learn paid child care, arrangements fell apart or were interrupted).
- You should be exempt or deferred.
- There is a family crisis.
- Any other "substantial and compelling reason" (according to the county).

Call Legal Services

Prepared by
Legal Services of Northern California
www.lsnc.net

CalWORKs

Making it Work for You

CalLearn

Teen Parents' Program

Your Rights

Sacramento County Department of Human Assistance
Building Bridges to Better Futures

Cal-Learn Program

Fact Sheet

The Teen Parent Program

What is the Cal-Learn Program?

The Cal-Learn program is operated by Sutter Medical Center to provide comprehensive case management services to teens who are pregnant or who already have a child. It is a statewide, mandatory program to encourage pregnant and parenting teens on welfare to graduate from high school or its equivalent and become self-sufficient.

Who participates in Cal-Learn?

Pregnant and parenting teens who are under the age of 19, who are receiving welfare and who have not graduated from high school or its equivalent.

What are the basic components of the Cal-Learn program?

Cash bonuses and grant sanctions that encourage teen parents to attend and progress in school toward graduation. Cal-Learn teens can earn up to four $100 bonuses or sanctions each year based on performance. Teens that receive report cards reflecting satisfactory progress (C average or better) may receive a $100 bonus to the Assistance Unit. For report cards reflecting unsatisfactory progress (less than a D average), the teen may receive a sanction of $100 that is applied to the Assistance Unit over a two month period.

Supportive services that help the teen parent through the challenges of parenting and attending school, including help with child care , transportation costs and costs associated with the education program in which they are participating.

Intensive case management to assist the teen parent in obtaining needed education, health and social services.

What is Cal-Learn's eligibility age requirement?

Cal-Learn's eligibility age limit was increased under CalWORKs to allow 19 year-old teens to continue their participation in the program, on a voluntary basis, with three qualifications:

- they were in Cal-Learn by age 18;
- they have not graduated from high school or its equivalent;
- they are attending school on a full-time basis, unless the county determines "good cause" for not meeting this requirement.

Other program components remain the same with intensive case management services provided and assistance with child care, transportation costs and other school expenses. Bonuses and sanctions continue to be based on school progress.

Does the CalWORKs 60-month time limits apply to teen parents?

No. The time during which a teen parent participates in the Cal-Learn program is not count toward the CalWORKs time limits.

How are Cal-Learn participants affected by the new school attendance requirements?

Teen parents who participate in the Cal-Learn program are not subject to the school attendance requirements. Cal-Learn participants continue to receive bonuses and sanctions based on academic performance.

How do I get more information about the Cal-Learn Program?

Call the Adolescent Family Life Program at (916) 334-0188 or visit the Sutter Women's and Children's Services web site: http://sutterwomens.org/commprgms/index.html.

CDSS Home
Food Stamps Home
FeedBack
Site Map

Food Stamp Programs

search
My CA This Site

Frequently Asked Questions

What can food stamp benefits be used to purchase?
Food Stamp benefits can be used to purchase:

- Foods for human consumption.
- Seeds and plants to grow food for household use.

What you cannot purchase with food stamp benefits?
Food Stamp benefits cannot be used to purchase:

- Any non-food item such as pet food; soaps, paper products, and household supplies; grooming items and cosmetics.
- Alcoholic beverages or tobacco products.
- Vitamins and medicines.
- Any food that will be eaten in the store.
- Any food marketed to be heated in the store.

Who can receive food stamp benefits?
You may be eligible to receive food stamp benefits, whether or not you work, if you have a low income.

What is the amount of food stamp benefits I will receive?
The amount of food stamp benefits a low-income person or family can receive is based on the U.S. Department of Agriculture's (USDA) Thrifty Food Plan. The plan estimates how much it costs to provide a household with nutritious, low-cost meals. The estimates are revised every year to keep pace with changes in food prices. The average amount of food stamp benefits received per household is about $200 per month.

What is the California Food Assistance Program (CFAP)?
CFAP is a state-funded food stamp program for legal permanent non-citizens residing in the U.S., and determined ineligible for federal food stamp benefits solely due to their immigration status.

Where do I go to apply for food stamp benefits?
There are over 240 food stamp offices in California operated by local county welfare departments. Low-income people may apply for food stamps at any office located in the county where they live. To find information on your county click on the link County Welfare Departments.

If I am receiving SSI/SSP, can I also receive food stamp benefits?
If you are receiving SSI/SSP, you cannot receive food stamp benefits in California. However, your family may be eligible to receive Food Stamp benefits.

Posted: 11-9-2004

Back to Top of Page

MEDI-CAL AND CPSP RESOURCE LIST

Medi-Cal Billing www.medi-cal.ca.gov	(800) 541-5555
Presumptive Eligibility Cynthia Cannon, Analyst cynthia.cannon@dhcs.ca.gov or Alice Mak, Supervisor alice.mak@dhcs.ca.gov	(800) 824-0088 (916) 552-9499 (916) 552-8002
Electronic Data Systems (EDS) **Perinatal Representatives** Billing Questions	(800) 541-5555 ***For CPSP*** *choose* ***option 15*** *then* ***press 12***
Medi-Cal Provider Enrollment	(916) 323-1945
Medi-Cal Fraud Reporting	(800) 822-6222
State Maternal, Child and Adolescent Health	(916) 650-0300
CA State University, Sacramento (State Contractor for CPSP Trainings) **Training Hotline**	(916) 278-4820 (800) 858-7743
MCH Access Project (For local perinatal access issues, Medi-Cal problems, training on eligibility for M/C, CalWorks, etc. - group meets 3rd Thursday of each month) www.mchaccess.org	(213) 749-4261
March of Dimes www.marchofdimes.com	(213) 637-5050

LA County CPSP Website: www.publichealth.lacounty.gov

COMPREHENSIVE PERINATAL SERVICES PROGRAM
600 S. Commonwealth Ave., Suite 800
Los Angeles, CA 90005
(213) 639-6419 FAX (213) 639-1034

Joanne Roberts, PHN
Perinatal Services Coordinator
(213) 639-6427
E-mail address: jroberts@ph.lacounty.gov

Otilia Elszy, PHN
Assistant Coordinator
South LA, Southeast LA Co.
(213) 639-6428
E-mail address: otelszy@ph.lacounty.gov

I. Jean Floyd, PHN
Assistant Coordinator
North LA, Co., San Gabriel Valley
(213) 639-6429
E-mail address: ifloyd@ph.lacounty.gov

Carol Phillips, PHN
Assistant Coordinator
Southwest LA. Co., So. Bay, Downtown LA
(213) 639-6426
E-mail address: cphillips@ph.lacounty.gov

Jenny Morales, PHN
Assistant Coordinator
Hollywood, SF Valley, Antelope Valley
(213) 639-6437
E-mail address: jmorales@ph.lacounty.gov

Thelma B. Hayes, M.A., R.D., CLE
Nutrition Consultant
(213) 639-6423
E-mail address: thayes@ph.lacounty.gov

Paula Binner, L.C.S.W.
Clinical Social Work Consultant
(213) 639-6424
E-mail address: pbinner@ph.lacounty.gov

Harold Sterker, M.P.H., C.H.E.S.
Health Education Consultant
(213) 248-1159 Cell
E-mail address: hsterker@ph.lacounty.gov

Christian Murillo, B.S.
Health Education Assistant
(213) 639-6422 Office
(323) 246-5487 Cell
E-mail address: cmurillo@ph.lacounty.gov

Bertha Solis
Staff Support
(213) 639-6445
E-mail address: bsolis@ph.lacounty.gov

City of Long Beach
Dept. of Health & Human Services
Karen Prochnow, PHN
Perinatal Services Coordinator
2525 Grand Avenue
Long Beach, CA90815
(562) 570-4209 (phone)
(562) 570-4099 (fax)
karen-prochnow@longbeach.gov

Pasadena City Health Dept.
Geraldine Perry-Williams, PHN
Perinatal Service Coordinator
1845 N. Fair Oaks Ave. 2nd Floor
Pasadena, CA 91103
(626) 744-6092 (phone)
(626) 744- 6112 (fax)
gperry-williams@cityofpasaden.net

CPSP Web Site Address: **www.publichealth.lacounty.gov**

County of Los Angeles Public Health
Comprehensive Perinatal Service Program (CPSP)
Training 'The Basics"
EVALUATION FORM

Date:_____

Experience in CPSP? [] Under 6 Mo. [] 6 Mo-1 Yr. [] 1-5Yrs. [] Over 5 Yrs. Date

CPSP Role: [] CPHW []MA []Office Manager []Biller []RN []PHN []MD []Other:_____

1.) Overall Evaluation of Workshop:	**Circle Your Rating**				
	Inadequate		**Good**		**Excellent**
a. The Objectives of the training were:	**1**	**2**	**3**	**4**	**5**
b. My knowledge of this subject <u>before</u> training.	**1**	**2**	**3**	**4**	**5**
c. My knowledge of this subject <u>after</u> training.	**1**	**2**	**3**	**4**	**5**
d. Amount I learned from this training	**1**	**2**	**3**	**4**	**5**
e. I found the handouts to be:	**1**	**2**	**3**	**4**	**5**
f. Overall, I consider this training:	**1**	**2**	**3**	**4**	**5**

2.) Please rate the following components of the training:					
	Poor				**Excellent**
a. Initial Combined Assessment (ICA) Trimester Reassessment/Postpartum	**1**	**2**	**3**	**4**	**5**
b. Problems/Issues List	**1**	**2**	**3**	**4**	**5**
c. Individualized Care Plan (ICP)	**1**	**2**	**3**	**4**	**5**
d. Use of Protocols and "Steps To Take"	**1**	**2**	**3**	**4**	**5**

3.) How effective was the presenter:	**Not effective**				**Very Effective**
Harold Sterker, MPH, CHES	**1**	**2**	**3**	**4**	**5**

4.) What information did you find most useful:

_____

_____

5.) What information from this training did you find least helpful:

_____

_____

7.) Training Needs/Topics (please specify):

_____

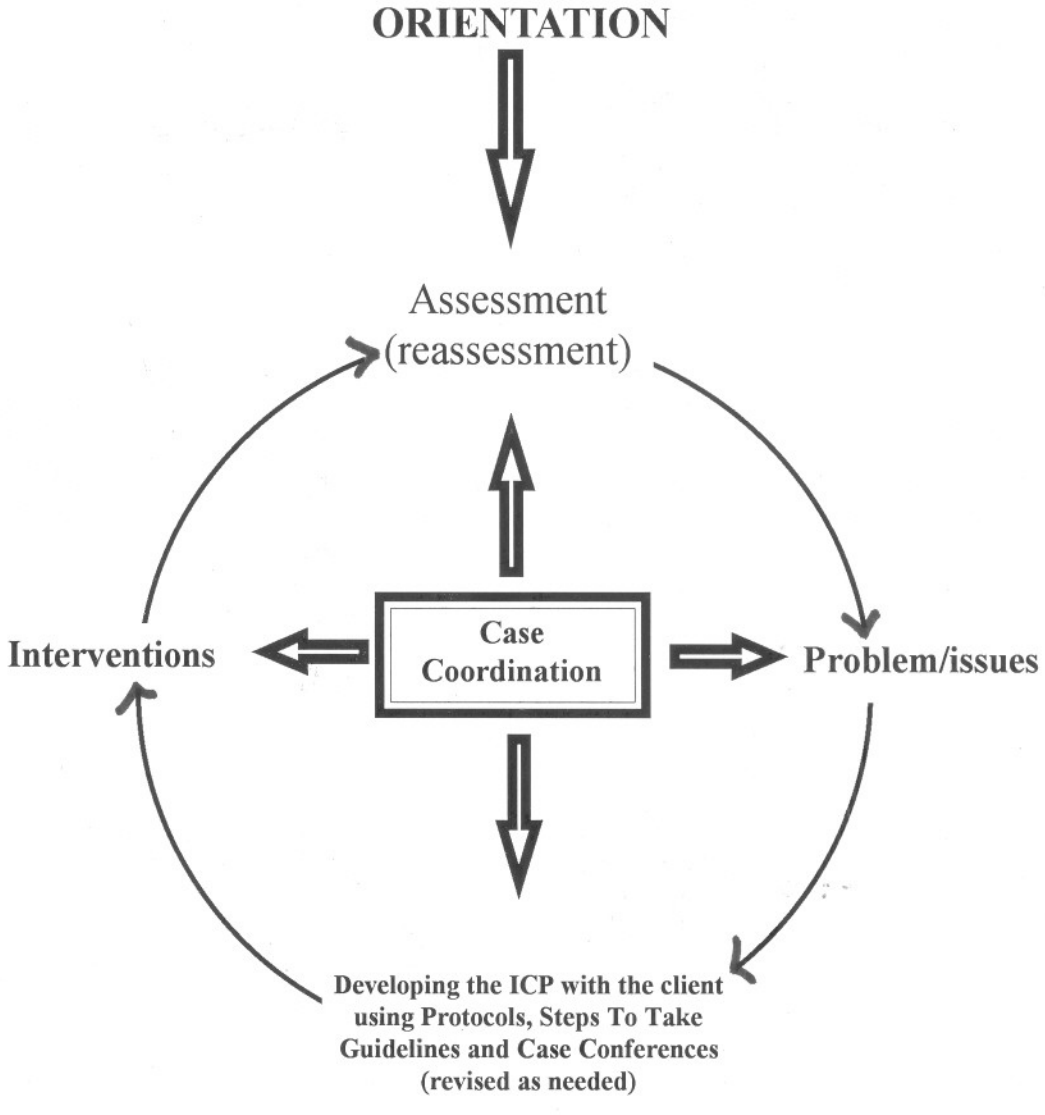
_____

8.) Your comments and recommendations are welcomed:

_____

_____

CPSP Components



c:Orientation Cycle.
Microsoft Publisher
3/27/00
aa

Keypoints for Client Orientation

- Orientation is a key activity for the smooth operation of the support services and a key to client satisfaction.

- Be familiar with the items required by CPSP regulations.

- Acknowledge and prepare the patient for the extra time commitment.

- Give a positive view of all CPSP services.

- Clearly explain the different roles of the different members of the health care professionals to provide the best possible care.

- Set the tone of collaboration with the patient to ensure the best possible outcome.

- Initial orientation should be started the first visit. Include information about: all services that will be available, the "Client's Rights and Responsibilities," administrative procedures of the office, limits of confidentiality, routine medical procedures that will be done, and written and verbal instructions about pregnancy warning signs/symptoms.

- Offer orientation for procedures such as ultrasound, stress testing and amniocentesis as the need arises at subsequent visits and throughout a patient's pregnancy.

Adapted from Brett-EPA training 94-95
LAC/DHS CPSP
Basic\keypoints.doc
cm

CPSP ORIENTATION CHECKLIST

Provider: _____

Patient: _____ DOB: _____ EDD: _____

Date Discussed	SUBJECT	Handout Given&Reviewed	
		Yes	No
_____	☐ Perinatal services to be provided (including CPSP) Name of Handout: *See Handout STT/HE-7	☐	☐
_____	☐ Who will provide services Name of Handout or N/A_____	☐	☐
_____	☐ Where services will be provided Name of Handout or N/A_____	☐	☐
_____	☐ Danger signs of pregnancy-what to do if they occur Name of Handout: *See Handout STT/HE-9	☐	☐
_____	☐ Patient Rights and Responsibilities Name of Handout:* See Handout STT/HE-11	☐	☐
_____	☐ HIV information/counseling given & HIV testing offered Name of Handout:* See Handout STT/HE-35	☐	☐
_____	☐ Substances to avoid during pregnancy Name of Handout or N/A_____	☐	☐
_____	☐ Group Classes available Name of Handout or N/A_____	☐	☐
_____	☐ Fetal movement monitoring (24-28 wks.) Name of Handout:_____	☐	☐
_____	☐ Integrated Prenatal Screening—(**a)**1st Trimester lab: 10 wks/0days-13 wks/6days. **(b)** 2nd Trimester lab: 15-wks/0 days- 20-wks/0 days. Name of Handout:_____	☐	☐
_____	☐ Genetic Risks/Testing Name of Handout or N/A_____	☐	☐
_____	☐ Delivery Site Options Name of Handout or N/A_____	☐	☐
_____	☐ Financial Responsibility Name of Handout or N/A_____	☐	☐
_____	☐ Other Subject/s_____	☐	☐
		☐	☐

The information checked above has been reviewed with me and I have had the opportunity to ask questions. I understand that as an active participant in my perinatal care, it is my responsibility to ask questions when I have a concern or problem.

Date				Client Signature		Practitioner /CPHW Signature		Total Minutes
		Initial Client Orientation						
		Follow-Up Orientation						
		Follow-Up Orientation						
		Follow-Up Orientation						

Prenatal Combined Assessment/Reassessment

Instructions for Use and Protocols

The Prenatal Combined Assessment/Reassessment Tool is designed to be completed by any qualified Comprehensive Perinatal Services Program (CPSP) practitioner, as defined in Title 22, Section 51179.7.

PURPOSE:

The Prenatal Combined Assessment/Reassessment tool permits the CPSP practitioner to assess the client's strengths, identify issues affecting the client's health and her pregnancy outcome, her readiness to take action, and resources needed to address the issues. This information, along with the information from the initial obstetrical assessment, is used, in consultation with the client, to develop an Individualized Care Plan (ICP). The combined assessment is ideal for those practice settings in which one CPSP practitioner is responsible for completing the client's initial assessment and reassessments. It does not preclude discipline specialists from providing needed services to the client.

This assessment/reassessment tool was designed to meet State WIC requirements for a nutrition assessment permitting WIC nutritionists to avoid a duplicative assessment and spend their time in educational or other "value added" activities to benefit pregnant Medi-Cal beneficiaries.

PROCEDURES/PROCESS:

The prenatal combined assessment tool is designed to be administered by a qualified CPSP practitioner (CPHW or other).

1. Refer to the CPSP Provider Handbook, pages 2-5 through 2-15.

2. Familiarize yourself with the assessment questions and the client's medical record before completing the assessment.

3. The setting should allow for adequate privacy. Due to the sensitive nature of the questions being asked, it is strongly recommended that the client's partner and other family members and friends be excluded during the administration of the assessment. This is one way to promote complete honesty in your client's responses and protect her right to confidentiality. Cultural customs and practices should be taken into consideration for each client.

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Prenatal Combined Assessment / Reassessment Tool

Initial _____/_____ (1st OB) Date Weeks 2nd Trimester _____/_____ (14-27 weeks) Date Weeks 3rd Trimester _____/_____ (28 weeks-Delivery) Date Weeks

This Prenatal Combined Assessment /Reassessment Tool has received California State Department of Health Services approval and **MAY NOT BE ALTERED** except to be printed on your logo stationery.

Patient Name:_____ Date Of Birth:_____

Health Plan:_____ Identification No.: _____

Provider:_____ Hospital: _____ Location: _____

Case Coordinator/Manager:_____ EDC: _____

Dx. OB High Risk Condition:_____

Personal Information

1. Patient age: ❑ Less than 12 years ↙ ❑ 12-17 years ↙ ❑ 18-34 years ❑ 35 years or older
2. Are you: ❑ Married ❑ Single ❑ Divorced/Separated ❑ Widowed ❑ Other: _____
3. How long have you lived in this area? _____ yrs./mos. Place of birth: _____
4. Do you plan to stay in this area for the rest of your pregnancy? ❑ Yes ❑ No
5. Years of education completed: ❑ 0-8 years ❑ 9-11 years ❑ 12-16 years ❑ 16+ years
6. What language do you prefer to speak: ❑ English ❑ Spanish ❑ Other: _____
7. What language do you prefer to read: ❑ English ❑ Spanish ❑ Other: _____
8. Which of the following best describes how you read:
   ❑ Like to read and read often ❑ Can read, but read slowly or not very often ❑ Do not read
9. Father of baby: (name) _____ His preferred language: _____ Education: _____ Age: _____
10. Was this a planned pregnancy? ❑ Yes ❑No
11. How do you feel about being pregnant now?
    0-13 wks: ❑ Good ❑ Troubled, please explain: _____
    14-27 wks: ❑ Good ❑ Troubled, please explain: _____
    28-40 wks: ❑ Good ❑ Troubled, please explain: _____
12. Are you considering (circle)adoption/abortion? ❑ No ❑ If Yes, Do you need information/referrals? O No O Yes
13. How does the father of the baby feel about this pregnancy? _____
    Your family? _____
    Your friends? _____

Economic Resources

14. a) Are you currently working or going to school? ❑ Yes - type & hr/week: _____ Cal Learn? ❑ Yes ❑No

b) Do you plan to work or go to school while you are pregnant? ❑ Yes - type: _____ How long?____ ❑No

c) Do you plan to return to work or go to school after the baby is born? ❑ Yes type: _____ ❑No

15. Will the father of the baby provide financial support to you and/or the baby? ❑ Yes ❑ No

Other sources of financial help? _____

16. Are you receiving any of the following? (check all that apply)

	0-13 wks:		14-27 wks:		28-40 wks:		Referral Date
	Yes	No	Yes	No	Yes	No	
a. WIC	❑	❑	❑	❑	❑	❑	
b. Food Stamps	❑	❑	❑	❑	❑	❑	
c. AFDC/TANF	❑	❑	❑	❑	❑	❑	
d. Emergency Food Assistance	❑	❑	❑	❑	❑	❑	
e. Pregnancy-related disability insurance benefits	❑	❑	❑	❑	❑	❑	
f. Other:_____	❑	❑	❑	❑	❑	❑	

17. Do you have enough of the following for yourself and your family?

	0-13 wks:		14-27 wks:		28-40 wks:	
	Yes	No	Yes	No	Yes	No
Clothes	❑	❑	❑	❑	❑	❑
Food	❑	❑	❑	❑	❑	❑

Housing

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

Any Changes? ❑ No ❑ Yes 14-27 wks: _____ ❑ No ❑ Yes 28-40 wks: _____

19. Do you have the following where you live? ↙ ❑ Yes 0-13 wks ❑ Yes 14-27 wks ❑ Yes 28-40 wks

0-13 wks:	**No:**	❑ toilet	❑ stove/place to cook↙	❑ tub/shower	❑ electricity	❑ refrig. ↙	❑ hot/cold water	❑ phone
14-27 wks:	**No:**	❑ toilet	❑ stove/place to cook↙	❑ tub/shower	❑ electricity	❑ refrig. ↙	❑ hot/cold water	❑ phone
28-40 wks:	**No:**	❑ toilet	❑ stove/place to cook↙	❑ tub/shower	❑ electricity	❑ refrig. ↙	❑ hot/cold water	❑ phone

20. Do you feel your current housing is adequate for you? ❑ Yes ❑ No, please explain: _____

21. Do you feel your home is safe for you and your children? ❑ Yes 0-13 wks ❑ Yes 14-27 wks ❑ Yes 28-40 wks

❑ No 0-13 wks, please explain: _____

❑ No 14-27 wks, please explain: _____

❑ No 28-40 wks, please explain: _____

22. If there are guns in your home, how are they stored? _____ ❑ N/A

23. Do any of your children or your partner's children live with someone else? ❑ N/A ❑ No

❑ If Yes, please _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Transportation

24. Will you have problems keeping your appointments/attending classes? ❑ No 0-13 wks: ❑ No 14-27 wks: ❑ No 28-40 wks:

❑ Yes 0-13 wks: ❑ Transportation ❑ Child care ❑ Work ❑ School ❑ Other: _____
❑ Yes 14-27 wks: ❑ Transportation ❑ Child care ❑ Work ❑ School ❑ Other: _____
❑ Yes 28-40 wks: ❑ Transportation ❑ Child care ❑ Work ❑ School ❑ Other: _____

25. When you ride in a car, do you use seatbelts? ❑ Never ❑ Sometimes ❑ Always

26. Do you have a car seat for the new baby?
0-13 weeks: ❑ Yes ❑ No 14-27 weeks: ❑ Yes ❑ No 28-40 weeks: ❑ Yes ❑ No

27. How will you get to the hospital? 14-27 weeks: _____ 28-40 weeks: _____

Current Health Practices

28. Do you know how to find a doctor for you and your family? ❑ Yes ❑ No, explain: _____

29. Do you have a doctor for your baby? 14-27 wks: ❑ Yes ❑ No 28-40 wks: ❑ Yes ❑ No Who? _____

30. Have you been to a dentist in the last year? ❑ Yes ❑ No Any dental problems? ❑ No ❑ Yes, please describe:

31. On average, how many total hours at night do you sleep? 0-13 wks: _____ 14-27 wks: _____ 28-40 wks: _____
On average, how many total hours do you nap in the day? 0-13 wks: _____ 14-27 wks: _____ 28-40 wks: _____

32. Do you exercise? ❑ No ❑ Yes, what kind? _____ How often? Minutes/day _____ days/week _____

33. Are you smoking/using chewing tobacco now? ↙ ❑ No 0-13 wks ❑ No 14-27 wks ❑ No 28-40 wks

0-13 wks: ❑ If Yes, for how many years? _____ How much per day? _____ Have you tried to quit? ❑ Yes ❑ No
14-27 wks: ❑ If Yes, how much per day? _____ Have you tried to quit during this pregnancy? ❑ Yes ❑ No
28-40 wks: ❑ If Yes, how much per day? _____ Have you tried to quit during this pregnancy? ❑ Yes ❑ No

34. Are you exposed to second-hand smoke? ↙ at home? ❑ No ❑ Yes at work? ❑ No ❑ Yes

35. Do you handle or have exposure to chemicals? (examples: glue, bleach, ammonia, pesticides, fertilizers, cleaning solvents, etc.)
0-13 wks: (circle) At work – home – hobbies? ❑ No ❑ Yes, _____
14-27 wks: (circle) At work – home – hobbies? ❑ No ❑ Yes, _____
28-40 wks: (circle) At work – home – hobbies? ❑ No ❑ Yes, _____

36. In your home, how do you store the following? ❑ Vitamins: _____
❑ Medications: _____ ❑ Cleaning agents: _____

Pt. Name _____
Date of Birth _____
Health Plan: _____
Identification No.: _____

37. Are you taking any prescription, over-the-counter, herbal or street drugs? ↙

❑ None 0-13 weeks ❑ None 14-27 weeks ❑ None 29-40 weeks

Examples: Tylenol®, Tums®, Sudafed®, laxatives, appetite suppressants, aspirin, prenatal vitamins, iron, allergy medications, Aldomet®, Prozac®, ginseng, manzanilla, greta, magnesium, yerba buena, marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other?

❑ Yes, 0-13 weeks: _____

❑ Yes, 14-27 weeks: _____

❑ Yes, 28-40 weeks: _____

38. How much of the following do you drink per day? ↙ ____ Water ____ Milk ____ Juice ____ Decaf Coffee

____ Coffee ____ Punch, Kool-Aid, Tang ____ Soda ____ Diet Soda ____ Herb tea

____ Beer ____ Wine ____ Wine Coolers ____ Hard Liquor ____ Mixed Drinks

14-27 wks: Has this changed? ❑ No ❑ Yes, how? _____

28-40 wks: Has this changed? ❑ No ❑ Yes, how? _____

39. If you use drugs and/or alcohol, are you interested in quitting? ❑ Yes ❑ No

Have you tried to quit? ❑ Yes ❑ No comments: _____

Pregnancy Care

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

41. Do you plan to have someone with you:

	14-27 weeks:			28-40 weeks:		
During labor?	❑ Yes	❑ No	❑ Unsure	❑ Yes	❑ No	❑ Unsure
When you first come home with the baby?	❑ Yes	❑ No	❑ Unsure	❑ Yes	❑ No	❑ Unsure

42. If you had a baby before, where was that baby(ies) delivered? ❑ N/A ❑ Hospital ❑ Clinic ❑ Home

❑ Other: _____ Were there any problems? ❑ No ❑ Yes, please explain: _____

43. Have you lost any children? ❑ No ❑ If Yes, please explain: _____

44. Do you have any traditions, customs or religious beliefs about pregnancy? ❑No ❑ If Yes, please explain: _____

45 Does the doctor say there are any problems with this pregnancy?

14-27 wks: ❑ No ❑ Yes please describe: _____

28-40 wks: ❑ No ❑ Yes please describe: _____

46. Are you scheduled for any tests?

14-27 wks: ❑ No ❑ If Yes, what: _____

28-40 wks: ❑ No ❑ If Yes, what: _____

Do you have any questions? ❑ No ❑ If Yes, what: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

47. Have you experienced any of the following discomforts during this pregnancy?

If Yes, check box:	0-13 wks:	14-27 wks:	28-40 wks:
Edema (swelling of hands or feet) ↙	❑	❑	❑
Diarrhea ↙	❑	❑	❑
Constipation ↙	❑	❑	❑
Nausea/vomiting ↙	❑	❑	❑
Leg cramps ↙	❑	❑	❑
Hemorrhoids	❑	❑	❑
Heartburn	❑	❑	❑
Vaginal Bleeding	❑	❑	❑
Varicose veins	❑	❑	❑
Headaches	❑	❑	❑
Backaches	❑	❑	❑
Abdominal cramping/contractions	❑	❑	❑
Other: _____		Othe _____	Other: _____

48. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive this time?
❑ N/A ❑ No ❑ If Yes, please explain: _____

49. Who has given you the most advice about your pregnancy? _____

50. What are the most important things they have told you? _____

51. Are you planning to use birth control after this pregnancy?

14-27 wks: ❑No ❑ Undecided If Yes, ❑ what method?

(circle) Birth control pills Diaphragm Norplant IUD Abstinence
Foam and/or condoms Natural family planning Tubal/Vasectomy Depoprovera

28-40 wks: ❑ No ❑ Undecided If Yes, ❑ what method?

(circle) Birth control pills Diaphragm Norplant IUD Abstinence
Foam and/or condoms Natural family planning Tubal/Vasectomy Depoprovera

52. Your current or past behaviors, or the current or past behaviors of your sexual partner(s) may place you at risk for being / becoming infected with HIV, the virus which causes AIDS. Since 1979 have you or any of your sexual partner(s):

(check all that apply)	self	partner(s)	unknown	no
Had sex with more than one partner?				
Had sex with someone you/they didn't know well?				
Been treated for trichomonas, chlamydia, genital warts, syphilis, gonorrhea, or other sexually transmitted infections?				
Had sex with someone who used drugs?				
Had hepatitis B?				
Shared needles?				
Had a blood transfusion since1979?				

Is there any other reason you think you might be at risk for HIV/AIDS? ❑ No ❑ If Yes, please explain: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Change in HIV risk status? 14-27 weeks: ❑ No ❑ Yes, what? _____

28-40 weeks: ❑ No ❑ Yes, what? _____

53. Have you been offered counseling/information on the benefits of HIV testing and been offered a blood test for HIV?

0-13 wks: ❑ No (Refer to OB provider)

14-27 wks: ❑ No (Not applicable if previous Yes answer)

28-40 wks: ❑ No (Not applicable if previous Yes answer)

❑ If Yes, do you have any questions? _____

Educational Interests

54. If you have had experience or received education/information in any of the following topics check Column A. If would you like more information check Column B.

TOPIC	0-13 WKS		14-27 WKS		28-40 WKS		Educational Materials Provided		
	A	B	A	B	A	B	Date	Code*	Initials
How your baby grows (fetal development)									
How your body changes during pregnancy									
Healthy habits for a healthy pregnancy/baby									
Assistance with cutting down/quitting smoking									
Assistance with cutting down/quitting alcohol or drugs									
What happens during labor and delivery									
Hospital Tour									
Helping your child(ren) get ready for a new baby									
How to take care of yourself after the baby comes									
Breastfeeding									
How to take care of your baby/infant safety									
Infant development									
How to avoid sexually transmitted infections/HIV									
Circumcision									

* Teaching Codes: A = Answered questions; W = Written material provided; E = Explained verbally; S = Visual aids shown; V = Video shown; I = Interpreter used

55. Is there anything special you would like to learn? ❑ No ❑ Yes, what? _____

56. How do you like to learn new things? ❑ Read ❑ Talk one-on-one ❑ Group education/classes ❑ Watch a Video ❑ Pictures and diagrams ❑ Being shown how to do it ❑ Other: _____

57. Will someone be able to attend classes with you? ❑ No ❑ Yes, who? _____

58. Do you have any physical, mental, or emotional conditions, such as learning disabilities, Attention Deficit Disorder, depression, hearing or vision problems that may affect the way you learn? ❑ No ❑ Yes: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Anthropometric:

59. Weight gain in previous pregnancies: 1st: _____ ❑ Unknown 2nd: _____ ❑ Unknown ❑ N/A

Recommended weight gain during pregnancy (check one)

60. Prepregnant weight: _____ lbs. ❑ for underweight women 28-40 lbs. ❑ for normal weight women 25-35 lbs.

61. Net weight gain: _____ lbs. ❑ for overweight women 15-25 lbs ❑ for very overweight women 15-20 lbs

❑ Adequate ❑ Inadequate ❑ Excessive ❑ Weight loss ❑ Weight grid plotted

Biochemical Data:

62. Urine-Date: _____ (circle + or -) Glucose: + - Ketones: + - Protein: + -

63. Blood-Date drawn: _____ Hgb: _____ (<10.5) Hct: _____ (< 32) MCV: _____ Glucose: _____

Clinical Data:

64. ❑ None relevant 65. ❑ Age 17 or less (#1) 66. ❑ Pregnancy interval < 1 yr.

67. ❑ High Parity (≥4 births) 68. ❑ Multiple Gestation 69. ❑ Currently Breastfeeding

70. ❑ Dental Problems (#30) 71. ❑ Serious Infections 72. ❑ Anemia

73. ❑ Diabetes (circle) Prepreg Past preg Current preg comments: _____

74. ❑ Hypertension (circle) Prepreg Past preg Current preg comments: _____

75. ❑ Hx. of poor pregnancy outcome (e.g., preterm delivery, fetal/neonatal loss): _____

76. ❑ Other medical/obstetrical problems (low birth weight, large for gest. age, PIH): Past: _____

Present: _____

77. Psychosocial or Health Education Problems: ❑ Eating disorder ❑ Psychiatric illness (#99) ❑ Abuse (# 102-106)

❑ Homelessness (#18) ❑ Dev. disability (#58) ❑ Low education (#5) ❑ Other: _____

Dietary:

78. Any discomforts? (#47) ❑ No ❑ If Yes, please check: ❑ Nausea ❑ Vomiting ❑ Swelling ❑ Diarrhea

❑ Constipation ❑ Leg cramps ❑ Other: _____

79. Do you ever crave/eat any of the following? ❑ No, ❑ If Yes, please check ❑ Dirt ❑ Paint chips ❑ Clay

❑ Ice ❑ Paste ❑ Freezer Frost ❑ Cornstarch ❑ Laundry starch ❑ Plaster ❑ Other: _____

80. a) Number of meals/day : _____ b) meals often skipped? ❑ No ❑ Yes c) Number of snacks/day : _____

81. Who does the following in your home: a) buys food: _____ b) prepares food : _____

82. Do you have the following in your home: (#19) a) stove/place to cook? ❑ No ❑ Yes b) refrigerator? ❑ No ❑

83. Are you on any special diet? ❑ No ❑ If yes, please explain: _____

84. a) Any food allergies? ❑ No ❑ If yes, please explain: _____

b) Any foods/beverages you avoid? ❑ No ❑ If yes, please explain: _____

85. Are you a vegetarian? ❑ No ❑ If Yes, do you eat: ❑ Milk Products ❑ Eggs ❑ Nuts ❑ Dried Beans ❑ Chicken/Fish

86. Substance use? ❑ No ❑ Alcohol (#38) ❑ Drugs (#37) ❑ Tobacco (#33) ❑Secondhand smoke (# 34)

❑ Present: _____ ❑ Past: _____

87. Currently use? (#37) ❑ None ❑ Prenatal vitamins ❑ Iron pills ❑ Other _____

❑ Herbal remedies: ❑ Antacids ❑Laxatives ❑ Other medicines: _____

88. Any previous breastfeeding experience? ❑ N/A ❑ No ❑ If Yes, how long? _____ ❑ < 1 month

Why did you stop? _____

89. Current infant feeding plans: ❑ Breast ❑ Breast & Formula ❑ Formula ❑ Undecided

90. **Nutrition Assessment Summary** ❑ 24 hour recall ❑ Food frequency (7 days)

a) **Food Group**	Servings/ Points	Suggested Changes		**Food Group**	Servings/ Points	Suggested Changes	
Protein		+ -		Vit. A-rich fruit/veg		+ -	
Milk products		+ -		Other fruit/veg		+ -	
Breads/cereals/grains		+ -		Fats/Sweets		+ -	
Vit. C-rich fruit/veg		+ -					

❑ **Referred to Registered Dietitian**

b) Diet adequate as assessed: ❑ Yes ❑ No **c) Excessive** ❑ Caffeine (#38)

Completed by: _____

Title: _____ Minutes: _____

Facility: _____ Telephone: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

GROUP	FOOD	POINTS NEEDED	SERVINGS/DAY	MAJOR NUTRIENTS
1	PROTEINS	21	3	PROTEIN, IRON, ZINC
2	MILK	21	3	CALCIUM, PROTEIN, VITAMIN D
3	BREADS, GRAINS	49	7	CARBOHYDRATES, B VITAMINS, IRON
4	FRUITS/VEGETABLES	7	1	VITAMIN C, FOLIC ACID
5	FRUITS/VEGETABLES	7	1	VITAMIN A, FOLIC ACID
6	FRUITS/VEGETABLES	21	3	CONTRIBUTES TO INTAKE OF VITAMINS A & C
OTHER	FATS AND SWEETS	N/A	3	VITAMIN E

Refer to Protocols for instructions on completing the dietary assessment using the point system above.

90. **(continued)**

14-27 weeks:

a) **Food Group**	**Servings/ Points**	**Suggested Changes**		
Protein		+ -		
Milk products		+ -		
Breads/cereals/grains		+ -		
Vit. C-rich fruit/veg		+ -		
Vit. A-rich fruit/veg		+ -		
Other fruit/veg		+ -		
Fats/Sweets		+ -		

b) **Diet adequate as assessed**: ❑ Yes ❑ No

c) **Excessive:** ❑ Caffeine (#38)

❑ Referred to Registered Dietitian

28-40 weeks:

a) **Food Group**	**Servings/ Points**	**Suggested Changes**		
Protein		+ -		
Milk products		+ -		
Breads/cereals/grains		+ -		
Vit. C-rich fruit/veg		+ -		
Vit. A-rich fruit/veg		+ -		
Other fruit/veg		+ -		
Fats/Sweets		+ -		

b) **Diet Adequate as assessed:** ❑ Yes ❑ No

c) **Excessive:** ❑ Caffeine (#38)

❑ Referred to Registered Dietitian

14-27 weeks: **Date:** _____

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

Net wt. gain: _____ (61) Protein: - +

❑ Adequate Ketones: - +

❑ Inadequate Blood drawn: date: _____

❑ Excessive Hgb: ___ Hct: ___ MCV: ___

28-40 weeks: **Date:** _____

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

Net wt. _____ (61) Protein: - +

❑ Adequate Ketones: - +

❑ Inadequate Blood drawn: date: _____

❑ Excessive Glucose ____ Hgb: ___ Hct: ___ MCV: ___

91. ❑ 3 Hr GTT: Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 Hr: _____ ❑ N/A (1 Hr < 140 dl/ml.)

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

92. Are you on any special diet? 14-27 weeks: ❑ No ❑ If Yes, please explain: _____

28-40 weeks; ❑ No ❑ If Yes, please explain: _____

93. Have your eating habits changed since you've been pregnant?

14-27 wks: ❑ No

❑ If Yes, how:

❑ Eat more: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

❑ Eat less: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

28-40 wks: ❑ No ❑ If Yes, how:

❑ Eat more: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

❑ Eat less: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

Coping Skills

94. Are you currently having problems/concerns with any of the following? (check all that apply)

	0-13 wks:	14-27 wks:	28-40 wks:
None	❑	❑	❑
Divorce/separation	❑	❑	❑
Recent death	❑	❑	❑
Illness (TB, cancer, abn. pap smear)	❑	❑	❑
Unemployment	❑	❑	❑
Immigration	❑	❑	❑
Legal	❑	❑	❑
Probation/parole	❑	❑	❑
Child Protective Services	❑	❑	❑
Other: _____	Other: _____	Other: _____	

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

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

97. What do you do when you are upset? _____

98. In the past month, how often have you felt that you could not control the important things in your life? ❑ No

❑ Very often ❑ Often ❑ Sometimes ❑ Rarely ❑ Never

99. Have you ever attended group or individual meetings for emotional support or counseling?

❑ If Yes, when and why? _____

❑ Yes Have you ever been prescribed drugs for emotional problems? ❑ What? _____ ❑ No

❑ Yes Have you ever been hospitalized for emotional problems? ❑ What year? _____ ❑ No

100. What do you do when you and your partner have disagreements? _____

101. Does your partner or other family member(s) use drugs and/or alcohol? ❑ No ❑ If Yes, does this create problems for you?

❑ No ❑ If Yes, Please explain: _____

102. Do you ever feel afraid of, or threatened by your partner? ❑ No ❑ If Yes, please explain: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

103. Within the last year have you been hit, slapped, kicked, choked or physically hurt by someone? ↙ ❑ No
❑ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

104. Since you have been pregnant, have you been hit, slapped, kicked, choked or physically hurt by someone? ↙

0-13 wks: ❑ No ❑ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

14-27 wks: ❑ No ❑ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

28-40 wks: ❑ No ❑ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

105. Within the last year has anyone forced you to have sexual activities? ↙ ❑ No ❑ If Yes, by whom (circle all that apply)

0-13 wks: ❑ No ❑ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

14-27 wks: ❑ No ❑ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

28-40 wks: ❑ No ❑ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

106. Are your children, or have your children ever been, a victim of violence or sexual abuse? ↙ ❑ No
❑ If Yes, please explain: _____

107. Would you feel comfortable talking to a counselor if you had a problem? ❑ No ❑ Yes

Initial Assessment Completed by:

Name and Title Initials Date Minutes

Second Trimester Reassessment Completed by:

Name and Title Initials Date Minutes

Third Trimester Reassessment Completed by:

Name andTitle Initials Date Minutes

Pt. Name _____
Date of Birth _____
Health Plan: _____
Identification No.: _____

COMPREHENSIVE PERINATAL SERVICES PROGRAM
COMBINED POSTPARTUM ASSESSMENT

Name:_____ **DOB:**_____ **Date:** _____ **I.D. No.**_____

Health Plan:_____ **Provider:** _____ **Delivery Facility:** _____

Anthropometric:

1. Height ____ 2. Desirable Body Wt. _____ 3. Total Pregnancy Wt. Gain _____ 4. Wt. this visit _____

5. Prepregnant wt. ____ 6. Postpartum Wt. Goal _____ 7. Weeks Postpartum this Visit _____

Biochemical:

Blood: Date Collected: _____

8. Hemoglobin: _____ (<10.5) 9. Hematocrit: _____ (<32) Other: _____

Urine: Date Collected: _____

10. Glucose: + - 11. Ketones: + - 12. Protein: + - Other: _____

13. Blood Pressure: ____ / ____ Comments: _____

Clinical - Outcome of Pregnancy:

14. Date of Birth: _____ 15. Gestational Age: _____ 16. Pregnancy/Delivery Complications: _____

17. Birth Weight:(gms) _____ 18. Birth Length (cm): _____

19. Current Weight: (gms) _____ 20. Current Length(cm): _____ Apgar Scores: 1 min: 5 min:

21. Type of Delivery: (circle) NSVD VBAC Vacuum Forceps C-Section (Primary or Repeat) (LTCS or Classical)

Maternal:

22. Have you had your postpartum check up? ❑Yes Date:

❑If No, when scheduled? _____

23. Any health problems since delivery? ❑Yes ❑No

If **YES**, please explain: _____

Infant:

24. Has infant had a newborn check-up?

If No, when scheduled? _____

If Yes, any Problems? _____

25. Number of NICU Days: _____

26. Infant exposure to: (circle all that apply)

Tobacco Alcohol Drugs

Nutrition:

27. **Maternal Dietary Assessment:** For ____ Day(s)

Food Group	Servs./ Points		Suggested Change
Protein	____	+ -	____
Milk Products	____	+ -	____
Breads/Cereals/Grains	____	+ -	____
Vit. C-rich fruit/veg	____	+ -	____
Vit. A-rich fruit/veg	____	+ -	____
Other fruit/veg	____	+ -	____
Fats/Sweets	____	+ -	

Dietary Goals:

Client agrees to:

REFERRALS: ❑ WIC Date Enrolled: _____

❑ Food Stamps ❑ Emergency Food ❑ AFDC

Diet adequate as assessed: ❑ Yes ❑ No Excessive: ❑ Caffeine

28. **Infant**

Method of Feeding: ❑ Breast ❑ Bottle ❑ Breast & Bottle # Wet diapers/day? _____

Type of Formula: _____ With Iron? ❑ Yes ❑ No _____ oz.. _____ times/day

29. Do you feel comfortable in your relationship with your baby? ❑ Yes ❑No _____
    Any special concerns? _____
30. Are you experiencing post-partum blues? ❑Yes ❑No _____
31. Have your household members adjusted to your baby? ❑Yes ❑No _____
32. Has your relationship with the baby's father changed? ❑Yes ❑No _____
33. Do you have the resources to assist in maximizing the health of you and your baby? ❑Yes ❑No
    If "No", indicate where needs exist: ❑Housing ❑Financial ❑Food ❑Family ❑ Other: _____
34. Outstanding issues from Prenatal Assessment/Reassessment: _____

Health Education

35. If breast feeding:
    Do you have enough milk? ❑Yes ❑No
    Do you supplement with formula? ❑Yes ❑No
    Does your baby take the breast easily? ❑Yes ❑No
    Are your nipples cracked and/or sore? ❑Yes ❑No
    Do you have any questions about breast feeding? ❑Yes ❑No
36. Do you have any questions about mixing or feeding formula? ❑Yes ❑No
37. Do you have any questions about your baby's health? ❑Yes ❑No
    If "Yes", please explain: _____
38. Do you have any questions about your baby's safety? ❑Yes ❑No
    If "Yes", please explain: _____
39. Are you using, or planning to use, any method of birth control? ❑Yes ❑No
    If "Yes", which one? _____
    If "No", would you like further information? _____

Plan:

Client Goals, Interventions and Timeline
Client agree to:

Referrals

Agency:_____ Date:_____ Agency:_____ Date:_____

Materials Given:

❑ Birth Control	❑ Infant Feeding	❑ Infant Care	❑ Infant Safety	❑ _____
❑ _____	❑ _____	❑ _____	❑ _____	❑ _____

Summary:

Date:_____ Interviewer:_____ Title_____ Minutes Spent:____

Copy of Individualized Care Plan sent to Patient's PCP on: (date) _____ by: (name and title)_____

INSTRUCTIONS ON HOW TO ASSESS WEIGHT GAIN/PLOT THE WEIGHT GAIN GRID

1. **Find the Woman's Weight Category.**
   - Ask the woman her weight before pregnancy.
   - Measure her without shoes. Find the woman's height on Table 1.
   - Follow across the columns to find her prepregnancy weight.
   - The title of the column with her prepregnancy weight tells you her weight category.
   - See "Prepregnancy Weight" for her specific weight category.

   Example:
   A woman is 5 feet 2 inches tall. She weighed 145 pounds before pregnancy.
   Her weight gain category is Overweight.

2. **Find the Recommended Range and Rate of Weight Gain.**

   - Find the "Recommended Total Weight Gain Range" for her weight category on Table 2.
   - Find the recommended $2^{nd}/3^{rd}$ trimester rate of gain per month for her weight category.

   Example:
   An Overweight woman is recommended to gain 15-25 pounds. A weight gain of 2 pounds per month is recommended during the 2^{nd} and 3^{rd} trimester.

3. **Find the Right Weight Gain Grid.**

   - The weight gain grid is a tool that you see if the woman is gaining within the recommended range.

   - Choose the weight gain grid that matches her weight category. These are three grids: Underweight, Normal or Overweight. If the woman is obese, use the Overweight grid.

   - **The Weight Gain Grid:** The horizontal zero line starts at conception. The vertical line represents the woman's weight before pregnancy. Each horizontal line above the zero represents one pound gained, and each line below is one pound lost. Each vertical line represents one week of gestation.

4. Plot the Weight Gain Grid.

- If she does not know her prepregnancy weight refer to the health care provider.
- Take the woman's weight today and subtract it from her prepregnancy weight. This number equals the number of pounds she has gained or lost.

  Example:
  A woman, 5 foot 2 inches weighed 145 pounds before pregnancy.
  At 18 weeks gestation she weighs 151 pounds (Lbs.).
  151 Lbs. – 145 Lbs. = 6 Lbs.
  She gained 6 Lbs.

- Find the line that marks her weight change and the line that marks the number of weeks gestation.
- Mark an X where these two lines meet.
- Check to see whether her total weight gain at this visit falls within her target weight gain range. In this example she is within the range for overweight women.
- Look at the rate of her weight gain. Is she gaining too fast, too slow or just right?
- Show the woman where her weight is on the grid. Educate her on her weight gain progress.
- Plot weight gain at **each prenatal** visit.

5. What Does the Weight Gain Grid Tell You?

- Weight gain can tell you if the woman is gaining too fast, too slow, or just right. The pattern of weight gain is as important as the total gain.
- The grid is also a screening tool to identify women who need more in-depth assessment.
- When a woman's gain is outside the recommended range, assess factors that ma affect her weight gain. See "Low Weight Gain" and "High Weight Gain".

  Some women may not follow the curves of the Weight Gain Grid or may be four or five pounds above or below the recommended line even though the are eating a nutritious diet. Other women may be eating too little or too much. It is important to find our what the woman is eating. Follow the guidelines for "Food Intake & Recall".

Table 1: Weight Categories for Women According to Height and Prepregnant Weight

Height (ft. in.)	Underweight (lbs)	Normal Weight (lbs)	Overweight (lbs)	Obese (lbs)
4'10"	94 or less	95 - 127	128 - 143	144 or more
4' 11"	97 or less	98 - 131	132 - 147	148 or more
5' 0"	100 or less	101 - 135	136 - 151	152 or more
5' 1"	102 or less	103 - 138	139 - 155	156 or more
5' 2"	106 or less	107 - 143	144 - 161	162 or more
5' 3"	109 or less	110 - 147	148 - 165	166 or more
5' 4"	112 or less	113 - 151	152 - 170	171 or more
5' 5"	116 or less	117 - 156	157 - 176	177 or more
5' 6"	119 or less	120 - 161	162 - 181	182 or more
5' 7"	123 or less	124 - 166	167 - 187	188 or more
5' 8"	126 or less	127 - 171	172 - 192	193 or more
5' 9"	131 or less	132 - 177	178 - 199	200 or more
5' 10"	134 or less	135 - 182	183 - 204	205 or more

Note: It is recommended that women who are smokers, African-American, or young adolescents should gain the upper end of the weight gain range for their category. Women who are short (less than 5 feet 2 inches) should gain at the lower end of the range for their category.

Table 2: Recommended Range and Rate of Weight Gain

Recommended	**Underweight**	**Normal Weight**	**Overweight**	**Obese**
Total Weight Gain Range:	28 to 40 lbs.	25 to 35 lbs.	15 to 25 lbs.	15 or more
Recommended $2^{nd}/3^{rd}$ Trimester Rage of Gain: (per month)	4 lbs or more	3-4 lbs.	about 2 lbs	varies

Name:

Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)[1]:

Height	Under Weight (BMI <18.5)	Normal Weight (BMI 18.5-24.9)	Over Weight (BMI 25-29.9)	Obese (BMI ≥ 30)
4'7"	< 80	80-107	108-128	> 128
4'8"	< 83	83-111	112-133	> 133
4'9"	< 86	86-115	116-138	> 138
4'10"	< 89	89-119	120-143	> 143
4'11"	< 92	92-123	124-148	> 148
5'	< 95	95-127	128-153	> 153
5'1"	< 98	98-132	133-158	> 158
5'2"	< 101	101-136	137-163	> 163
5'3"	< 105	105-140	141-169	> 169
5'4"	< 108	108-145	146-174	> 174
5'5"	< 111	111-149	150-179	> 179
5'6"	< 115	115-154	155-185	> 185
5'7"	< 118	118-159	160-191	> 191
5'8"	< 122	122-164	165-196	> 196
5'9"	< 125	125-168	169-202	> 202
5'10"	< 129	129-173	174-208	> 208
5'11"	< 133	133-178	179-214	> 214
6'	< 137	137-183	184-220	> 220
6'1"	< 140	140-189	190-227	> 227
6'2"	< 143	143-194	195-233	> 233
6'3"	< 148	149-199	200-239	> 239

BMI = Weight (lbs.)/Height (in.)² X 703

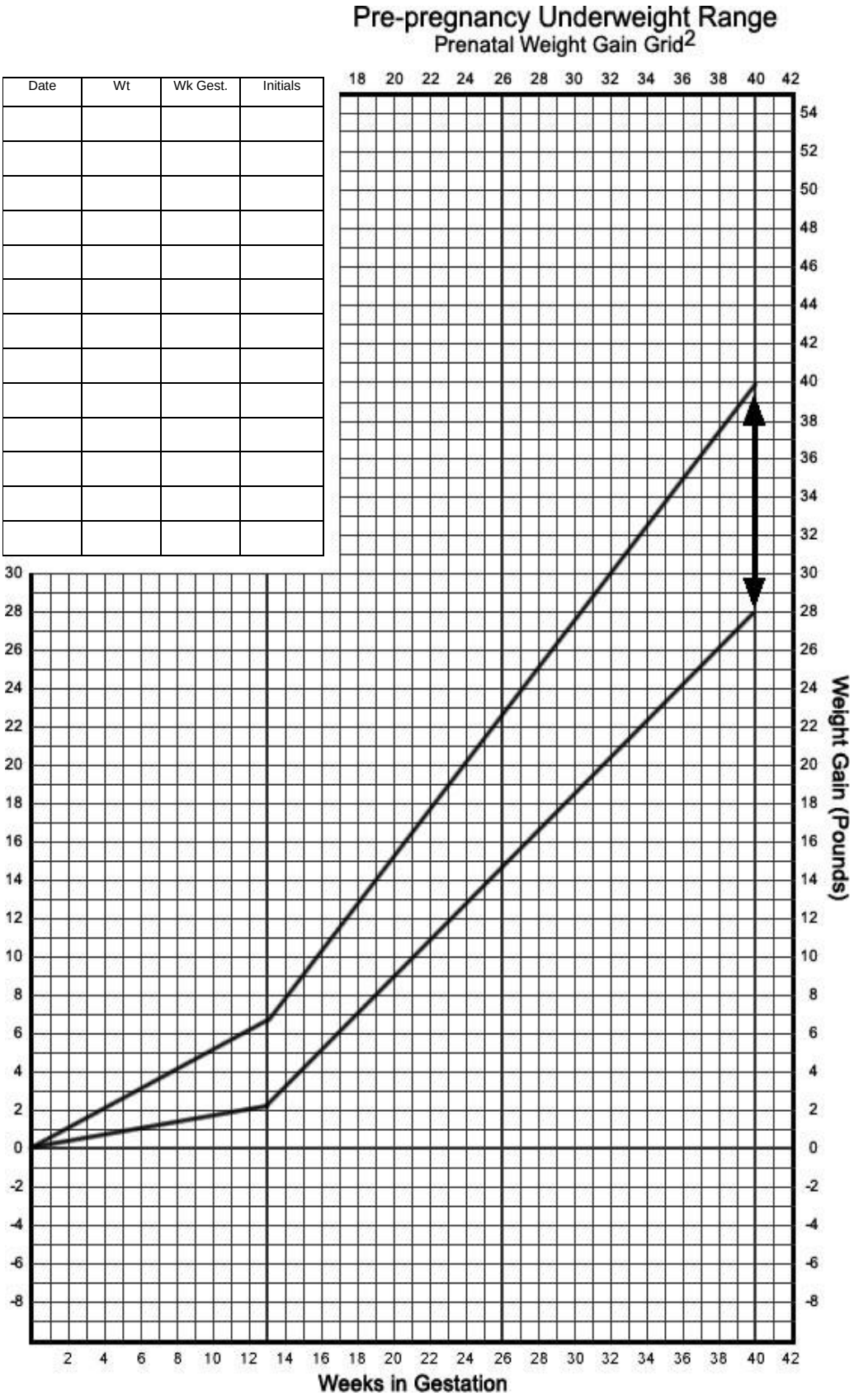
Recommended Weight Gain[1]:

Mark One:	Single	Twins
☐ Underweight	**28-40 lbs.**	N/A
☐ Normal	**25-35 lbs.**	37-54 lbs.
☐ Overweight	**15-25 lbs.**	31-50 lbs.
☐ Obese	**11-20 lbs.**	25-42 lbs.

Pre-pregnancy Weight: _____

Height: _____

Date	Wt	Wk Gest.	Initials



[1] IOM, 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines.* Washington, DC: National Academies Press.

[2] Per Personal Communication with the Committee to Reexamine IOM Pregnancy Weight Guidelines

Name:

Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)[1]:

Height	Under Weight (BMI <18.5)	Normal Weight (BMI 18.5-24.9)	Over Weight (BMI 25-29.9)	Obese (BMI ≥ 30)
4'7"	< 80	80-107	108-128	> 128
4'8"	< 83	83-111	112-133	> 133
4'9"	< 86	86-115	116-138	> 138
4'10"	< 89	89-119	120-143	> 143
4'11"	< 92	92-123	124-148	> 148
5'	< 95	95-127	128-153	> 153
5'1"	< 98	98-132	133-158	> 158
5'2"	< 101	101-136	137-163	> 163
5'3"	< 105	105-140	141-169	> 169
5'4"	< 108	108-145	146-174	> 174
5'5"	< 111	111-149	150-179	> 179
5'6"	< 115	115-154	155-185	> 185
5'7"	< 118	118-159	160-191	> 191
5'8"	< 122	122-164	165-196	> 196
5'9"	< 125	125-168	169-202	> 202
5'10"	< 129	129-173	174-208	> 208
5'11"	< 133	133-178	179-214	> 214
6'	< 137	137-183	184-220	> 220
6'1"	< 140	140-189	190-227	> 227
6'2"	< 143	143-194	195-233	> 233
6'3"	< 148	149-199	200-239	> 239

BMI = Weight (lbs.)/Height (in.)² X 703

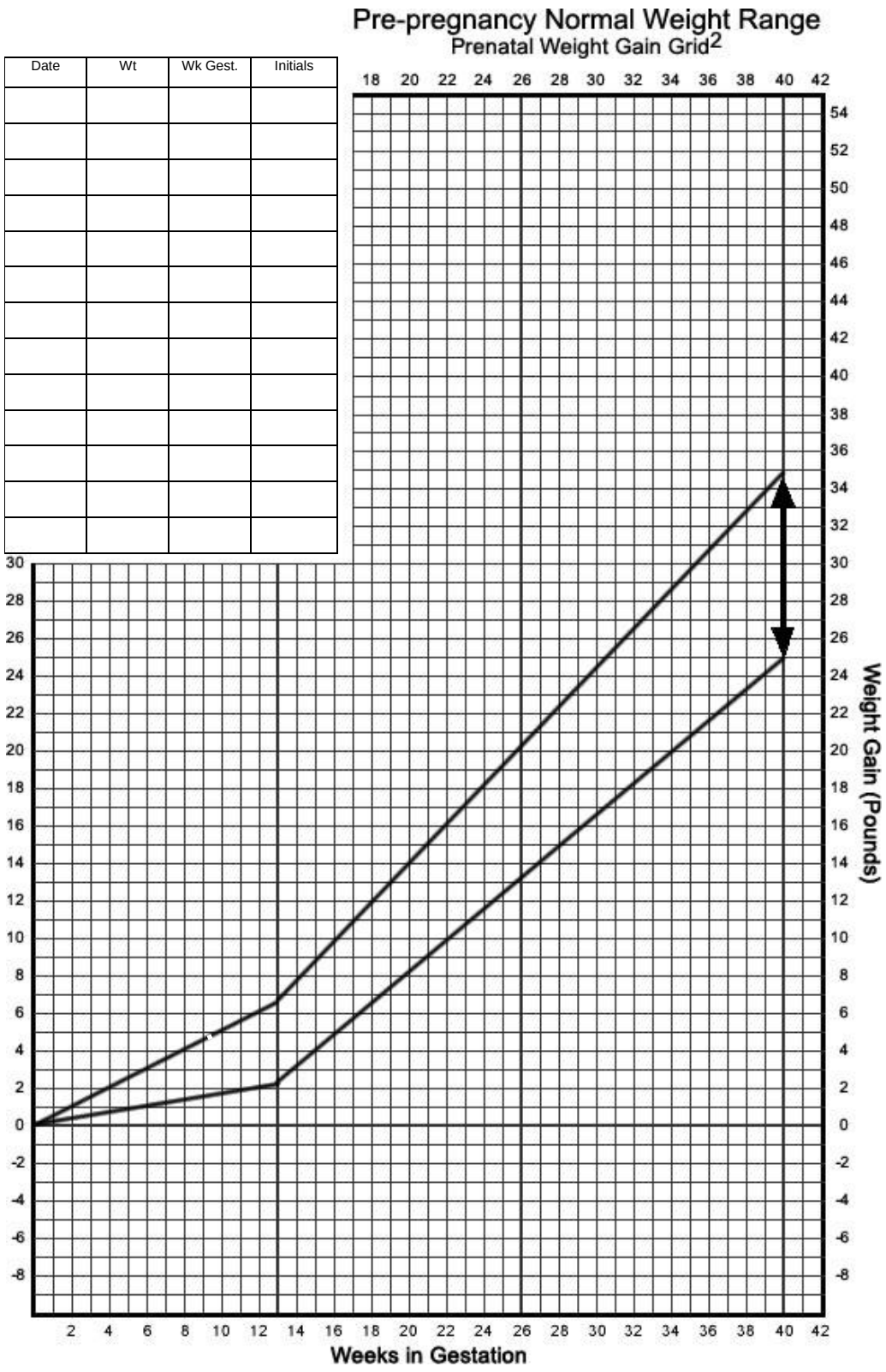
Recommended Weight Gain[1]:

Mark One:		Single	Twins
☐	Underweight	**28-40 lbs.**	N/A
☐	Normal	**25-35 lbs.**	37-54 lbs.
☐	Overweight	**15-25 lbs.**	31-50 lbs.
☐	Obese	**11-20 lbs.**	25-42 lbs.

Pre-pregnancy Weight: _____

Height: _____

Date	Wt	Wk Gest.	Initials



[1] IOM, 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines.* Washington, DC: National Academies Press.

[2] Per Personal Communication with the Committee to Reexamine IOM Pregnancy Weight Guidelines

Name: _____

Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)[1]:

Height	Under Weight (BMI <18.5)	Normal Weight (BMI 18.5-24.9)	Over Weight (BMI 25-29.9)	Obese (BMI ≥ 30)
4'7"	< 80	80-107	108-128	> 128
4'8"	< 83	83-111	112-133	> 133
4'9"	< 86	86-115	116-138	> 138
4'10"	< 89	89-119	120-143	> 143
4'11"	< 92	92-123	124-148	> 148
5'	< 95	95-127	128-153	> 153
5'1"	< 98	98-132	133-158	> 158
5'2"	< 101	101-136	137-163	> 163
5'3"	< 105	105-140	141-169	> 169
5'4"	< 108	108-145	146-174	> 174
5'5"	< 111	111-149	150-179	> 179
5'6"	< 115	115-154	155-185	> 185
5'7"	< 118	118-159	160-191	> 191
5'8"	< 122	122-164	165-196	> 196
5'9"	< 125	125-168	169-202	> 202
5'10"	< 129	129-173	174-208	> 208
5'11"	< 133	133-178	179-214	> 214
6'	< 137	137-183	184-220	> 220
6'1"	< 140	140-189	190-227	> 227
6'2"	< 143	143-194	195-233	> 233
6'3"	< 148	149-199	200-239	> 239

BMI = Weight (lbs.)/Height (in.)² X 703

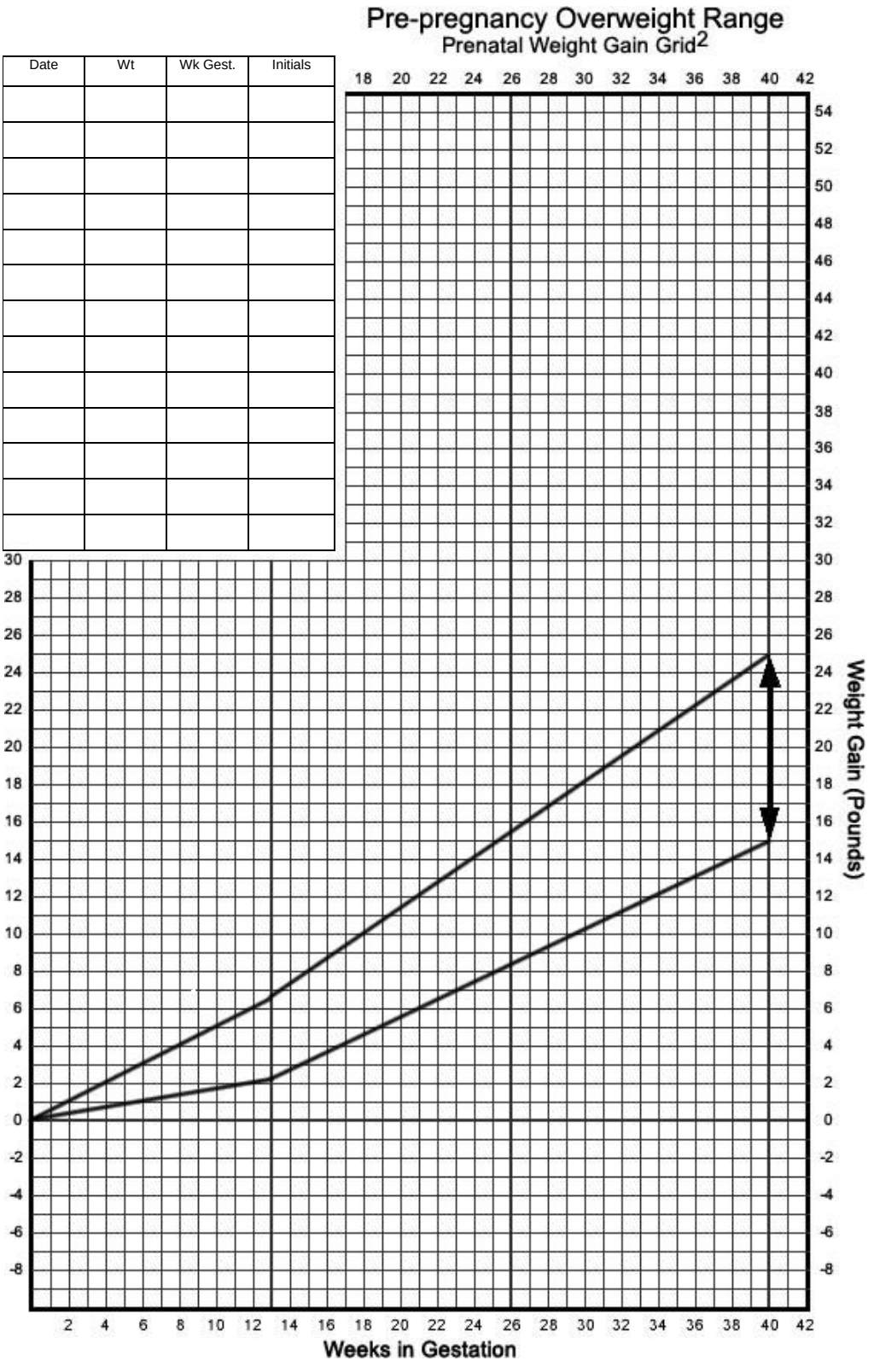
Recommended Weight Gain[1]:

Mark One:	Single	Twins
☐ Underweight	**28-40 lbs.**	N/A
☐ Normal	**25-35 lbs.**	37-54 lbs.
☐ Overweight	**15-25 lbs.**	31-50 lbs.
☐ Obese	**11-20 lbs.**	25-42 lbs.

Pre-pregnancy Weight: _____

Height: _____

Date	Wt	Wk Gest.	Initials



[1] IOM, 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines.* Washington, DC: National Academies Press.

[2] Per Personal Communication with the Committee to Reexamine IOM Pregnancy Weight Guidelines

Name:

Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)[1]:

Height	Under Weight (BMI <18.5)	Normal Weight (BMI 18.5-24.9)	Over Weight (BMI 25-29.9)	Obese (BMI ≥ 30)
4'7"	< 80	80-107	108-128	> 128
4'8"	< 83	83-111	112-133	> 133
4'9"	< 86	86-115	116-138	> 138
4'10"	< 89	89-119	120-143	> 143
4'11"	< 92	92-123	124-148	> 148
5'	< 95	95-127	128-153	> 153
5'1"	< 98	98-132	133-158	> 158
5'2"	< 101	101-136	137-163	> 163
5'3"	< 105	105-140	141-169	> 169
5'4"	< 108	108-145	146-174	> 174
5'5"	< 111	111-149	150-179	> 179
5'6"	< 115	115-154	155-185	> 185
5'7"	< 118	118-159	160-191	> 191
5'8"	< 122	122-164	165-196	> 196
5'9"	< 125	125-168	169-202	> 202
5'10"	< 129	129-173	174-208	> 208
5'11"	< 133	133-178	179-214	> 214
6'	< 137	137-183	184-220	> 220
6'1"	< 140	140-189	190-227	> 227
6'2"	< 143	143-194	195-233	> 233
6'3"	< 148	149-199	200-239	> 239

BMI = Weight (lbs.)/Height (in.)² X 703

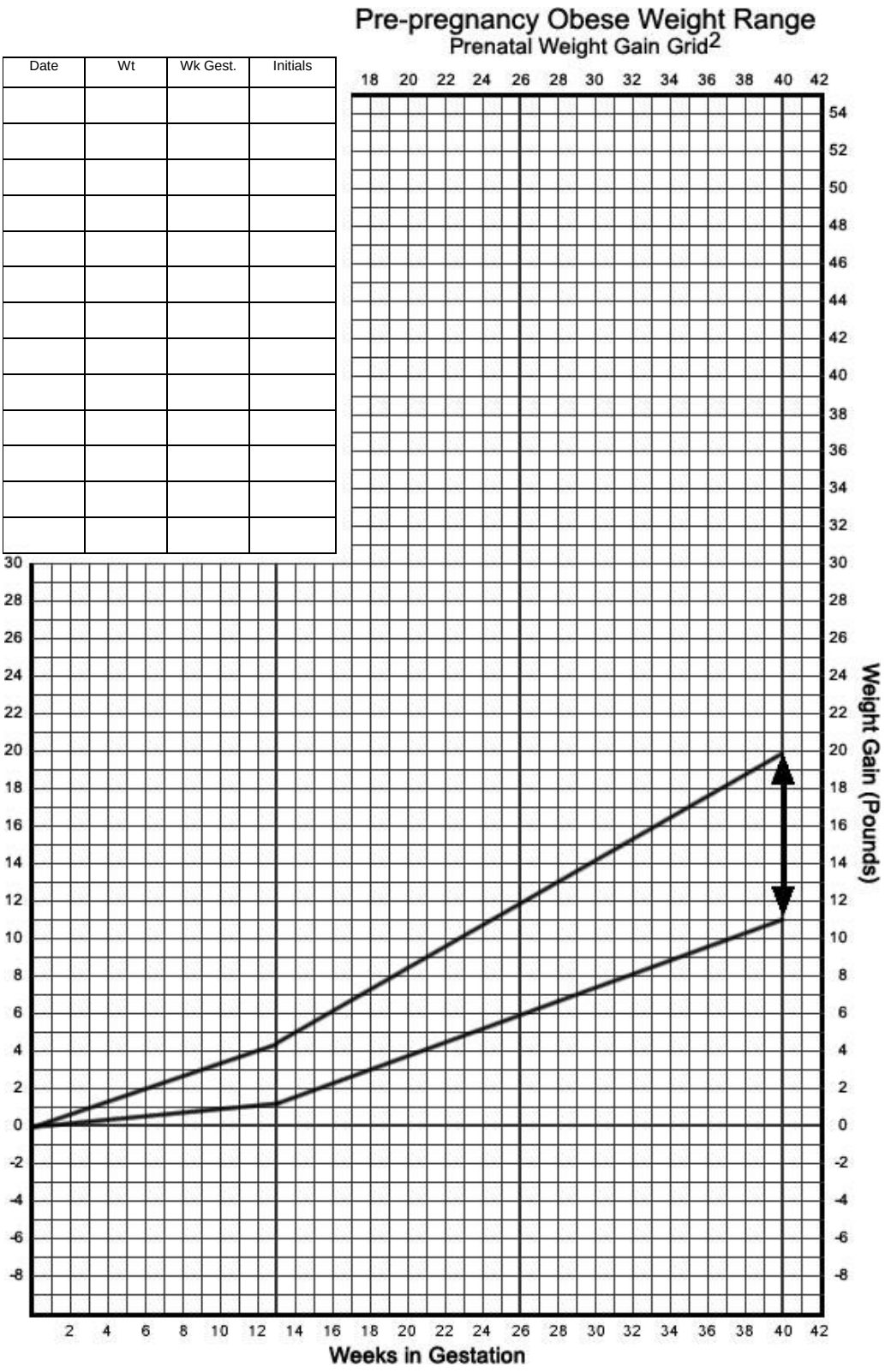
Recommended Weight Gain[1]:

Mark One:		Single	Twins
☐	Underweight	**28-40 lbs.**	N/A
☐	Normal	**25-35 lbs.**	37-54 lbs.
☐	Overweight	**15-25 lbs.**	31-50 lbs.
☐	Obese	**11-20 lbs.**	25-42 lbs.

Pre-pregnancy Weight: _____

Height: _____

Date	Wt	Wk Gest.	Initials



[1] IOM, 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines.* Washington, DC: National Academies Press.

[2] Per Personal Communication with the Committee to Reexamine IOM Pregnancy Weight Guidelines

INSTRUCTIONS FOR THE PERINATAL FOOD FREQUENCY QUESTIONNAIRE

The Perinatal Food Frequency Questionnaire (PFFQ) is used to determine the different foods a patient eats each day or week. This dietary information is used together with anthropometric (height/weight), biochemical (labs), and clinical information to complete the nutrition component of the Prenatal Initial Combined Assessment/Reassessment Tool (ICA).

FOOD INTAKE & FREQUENCY

A nutrition assessment needs to be completed on every woman, initially and at least once each trimester, *using a Perinatal Food Frequency Questionnaire*. The questionnaire will help the evaluator:

- assess the patient's nutritional status;
- compare what and how much she eats to the *Daily Food Guide* recommendations*;*
- help her find foods she enjoys in food groups where she doesn't eat enough; and
- learn about her food habits, culture, family, and lifestyle

HOW TO DO A PERINATAL FOOD FREQUENCY QUESTIONNAIRE - (PFFQ)

The Perinatal Food Frequency Questionnaire (PFFQ) uses the seven food groups from the *Daily Food Guide for Women*. Foods are grouped according to similar nutrients and one food can be exchanged for another within the same group. Eating the recommended number of servings in groups 1-6 assures that a pregnant or breastfeeding woman will eat at least 90% of the Recommended Dietary Allowances (RDA) for protein, vitamins, and minerals. Eating the recommended servings in the "Other Foods" group (identified with the triangle ▲ symbol), assures appropriate intake of unsaturated fats and vitamin E.

Either the client or evaluator can complete the questionnaire. The client instructions are at the top of the page of the PFFQ. **Note:** although it states "*if you eat the food less than 1* time *per week, do not mark columns*," this information must be reviewed and totaled by the evaluator who should fill in any blanks with a *"0"*. The "Other Foods" group is not scored, but is evaluated to capture the intake of unsaturated fats.

Record the final scores of the PFFQ in question #90 of the ICA- "Nutrition Assessment Summary". ***A completed PFFQ is also required for each trimester reassessment and postpartum assessment and must remain in the chart.*** Completing a PFFQ takes practice. Speed and accuracy will come as more questionnaires are completed.

The PFFQ uses a ***point system*** to determine if the diet is adequate. The points in the *bottom left corner* of each box – in parentheses - are equal to the recommended number of servings in the Daily Food Guide multiplied by 7 ***(1 serving equals 7 points).*** For example: In Group 1 (Protein), a patient needs 21 points. This is equal to 3 "servings." ***Follow the Steps Below:***

1. Explain what you are going to do:

"I am going to read off a list of foods. For each food tell me the number of times you eat that food every day. If you do not eat that food daily, tell me how many times you eat that food each week."

2. Fill out the PFFQ:

As you read off the foods, write in the client's answers. If she eats the food every day, write down her answer in the **Daily** column. If she does not eat a food every day, write down her answer in the **Weekly** column. If she eats the food less than one time per week, document a zero.

3. Score the PFFQ:

After filling out the answers for all the food groups, go back and add up the totals for groups 1-6. For each group:

a Add all the numbers in the **Daily** column and write that number on the **Subtotals** line, to the left of "___ x 7=". Multiply this number by 7 and write in the total to the right of the "x 7 =____ ".

b Add all the numbers in the **Weekly** column and write that total on the **Subtotals** line.

c Add the subtotals from the **Daily** column and **Weekly** column. Write the total on the last line next to **Total Points.**

4. **Discuss the changes she should make to her diet:**
Review each food group and provide suggestions to help client meet her needs. Use the following information to help evaluate her needs:

a Compare the **Total Points** of each group with the **Recommended Points** (found in *parentheses* in the lower left corner of each box (*shaded area*).

b If the **Recommended Points** are greater than the **Total Points,** the client is not meeting her minimum needs for that group. To advise her on how many servings to add to her daily diet **subtract** the **Total Points** from the **Recommended Points** and divide the answer by 7. This number is the number of servings from that group the client needs to add to her diet every day.

* The diet is low in total protein only if the combined points of groups 1 and 2 are less than 35.

***** A star (*****) next to a food indicates that this food is high in folate. A diet may be low in folate if the total for all starred foods is less than 7.

***** A triangle (▲) next to a food indicates that it is high in unsaturated fats. A diet may be low in unsaturated fats if the total intake is less than 3.

c If the **Total Points** is greater than the **Recommended Points** you will need to evaluate whether a decrease in servings is necessary. (Remember that the

Recommended Points is the minimum number suggested: a greater intake may be encouraged.) Use the following guidelines to advise the client:

Groups 1 & 2:
Encourage client to eat the lower fat sources from these groups (chicken, fish and beans from Group1; low-fat/nonfat dairy from Group 2). Determine whether a high intake of foods from these groups interferes with an adequate intake from other groups. If intake from these groups is very high, suggest replacing some servings from these groups with servings from the other groups that are deficient.

Group 3:
Encourage client to eat whole grains. Remind client to limit high fat additions to foods, like butter, margarine, or cream sauces. Determine whether a high intake of foods from this group interferes with an adequate intake from other groups. If intake from this group is very high, suggest replacing some servings from this group with servings from the other groups that are deficient.

Groups 4, 5, & 6:
A high intake from these groups should be encouraged. Remind client to eat a variety of foods from each group. Be sure fruit intake includes both juices and whole fruits. Remind client to limit intake of fried vegetables and limit higher fat additions to vegetables, like butter, cheese, or cream sauces.

"Other Foods" Group:
This group is not scored, but is important to evaluate the intake of unsaturated fats. In general, more than 3 servings per day of foods that are high in fat or sugar may lead to excess weight or displacement of more nutritious foods.

It is recommended that fat be limited to the items indicated with the triangle (▲), which are high in unsaturated fat. Encourage clients to eat these foods in moderation. Determine whether a high intake of foods from this group interferes with an adequate intake from other groups. If intake from this group is very high, suggest replacing some servings from this group with servings from groups that are deficient. Check the client's weight. If she is overweight, or if she is gaining weight too quickly, advise her to limit these foods. If she is underweight, or if she is gaining weight too slowly, advise her to eat adequate amounts from all the food groups, and then add these extra foods.

The PFFQ information needs to be transferred to the "Nutrition Assessment Summary" section (question #90) of the ICA. Transfer the **Total Points** from each food group (1-6) to the corresponding food group line in question # 90. (Remember to put a check ☑ in the box for "Food Frequency (7 days)" to indicate that you used a PFFQ rather than a 24-hour diet recall. Circle the word **"points"** in **Part a** "Food Group"/ column 2 "Servings/Points."

1. If **Recommended** Points are greater than **Total Points**:

    1. Subtract **Total Points** from **Recommended Points**.
    2. Divide this total by 7. Write this number in the column under **"Suggested Changes"**
    3. Circle the "+" sign under **"Suggested Changes."**

3. If the **Total Points** are greater than **Recommended Points**:

    a. Subtract **Recommended Points** from **Total Points**.
    b. Divide this total by 7. Write this number in the column under **"Suggested Changes"**
    c. Circle the "-" sign under **"Suggested changes."**

4. Complete **Part b** for initial assessment.

5. Repeat above steps for each reassessment and postpartum visit.

DIETARY ASSESSMENT SUMMARY
This section must be completed by the Evaluator for the Initial Combined Assessment (ICA), and for 2nd and 3rd trimester reassessments, and for postpartum assessment.

- Diet Inadequate/Excessive In:
Compare actual points with recommended points. Note which food groups/nutrients are inadequate or excessive and list them in appropriate areas. For initial assessment, transfer this information to the *"Nutrition Assessment Summary" of the ICA.*

- Comments /Needs:
Note any pertinent findings from Food Groups 1-6 and "Other Foods". This information may be useful in development of the Individualized Care Plan (ICP).

- Nutrition Intervention:
Summarize what you have done for the woman by checking the appropriate intervention(s) as follows:

>check when you have completed counseling for identified problems; check if you have given a brochure (*you may note which one*); check if you have referred high risk patients to the Registered Dietitian (R.D.) per protocols.

Sign and date tool; record the woman's name and ID/chart information.

Note: A 24-hour diet recall may be used instead of a Food Frequency Questionnaire, but the provider must demonstrate that staff have been adequately trained and knowledgeable in its use.

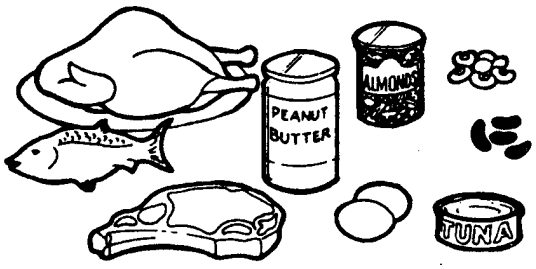
Please check one:
_Initial Assessment
_ 2nd Trimester Reassessment
_ 3rd Trimester Reassessment
_ Postpartum Assessment

Client Name:
I.D. Number:

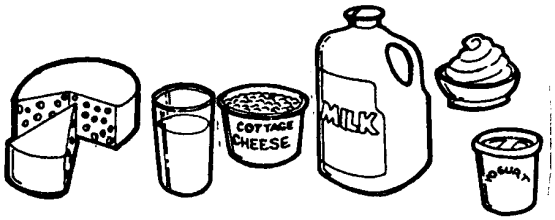
PERINATAL FOOD FREQUENCY QUESTIONNAIRE
(PFFQ)

(Client Instructions)
How often do you eat the food listed below?
If you eat the food every day, mark the number of times per day in the daily column.
If you eat the food one or more times per week (not every day), mark the number of times per week in the weekly column.
If you eat the food less than once per week. do not mark columns.

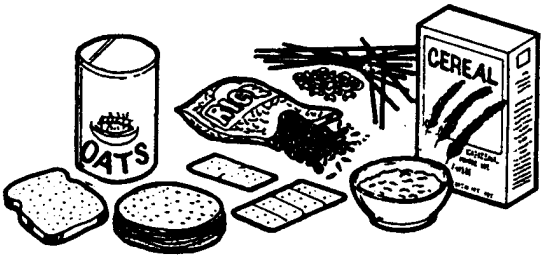
Group 1	Daily	Weekly
meat		
chicken		
fish		
shell fish		
eggs		
*beans		
peanut butter		
Subtotals:	x7=	+
(21)		Total Points:



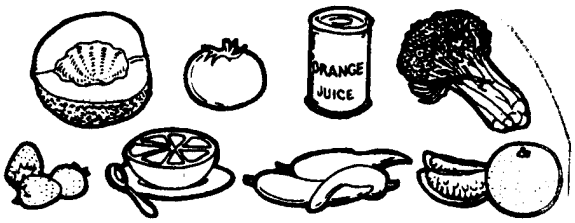
Group 2	Daily	Weekly
milk		
cheese		
yogurt		
Subtotals:	x7=	+
(21)		Total Points:



Group 3	Daily	Weekly
bread (1 slice)		
tortilla (1)		
cooked cereal		
dry cereal		
rice		
pasta		
Subtotals:	x7=	+
(49)		Total Points:

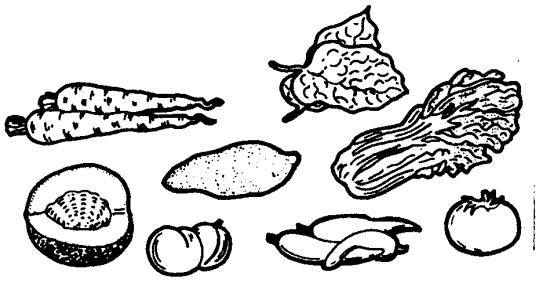


Group 4	Daily	Weekly
*orange		
*orange juice		
*tomato		
cabbage		
*broccoli		
*cauliflower		
Subtotals:	x7=	+
(7)		Total Points:

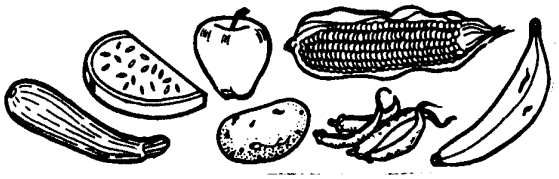


Client Name:
I.D. Number:

Group 5	Daily	Weekly
*spinache/greens		
sweet potato		
carrots		
cantaloupe		
mango		
Subtotals:	x7=	+
(7)		Total Points:



Group 6	Daily	Weekly
apple		
banana		
pineapple juice		
corn		
lettuce		
potatoes (white)		
zucchini		
other fruits & vegetables		
Subtotals:	x7=	+
(21)		Total Points:



Other Foods	Daily	Weekly
fried foods		
butter		
▲ margarine		
sour cream		
▲ mayonnaise		
▲ salad dressing		
▲ vegetable oil		
▲ avocado		
chips		
donuts		
candy		
soda		
other sugar drinks		

DIETARY ASSESSMENT SUMMARY

Diet Inadequate In:
(food groups/nutrients)

Diet Excessive In:

Comments/Needs:

☐ Brochures Given
☐ Counseled
☐ Referred to Nutritionist

_____
Name and Title of Evaluator/ Date

Individualized Care Plan (ICP)

Purpose:

To address client's problems/risks/concerns identified during prenatal visits, Prenatal Combined Assessment/Reassessment and/or Postpartum Assessment.

Definition:

The ICP is a document developed by a comprehensive perinatal practitioner(s) in conjunction with the client. The plan includes four components: obstetrical, nutritional, health education, and psychosocial. Each component includes identification of risk conditions, prioritization of needs, proposed intervention(s) including methods, timeframe, outcome goal, proposed referrals, and each health discipline's responsibilities based on the results of the assessments.

Procedure:

Client Information:

Patient:

Write in the client's complete name following the format of first name, middle initial and last name.

Gravida:

Write in the number of times the patient became pregnant including this one. All pregnancies should be counted regardless of whether they resulted in a live birth or not.

Para:

Write in the number of previous deliveries resulting in infants weighing 500 grams or more or having a gestational age of 20 weeks or more whether alive or dead at delivery. A multiple fetal pregnancy (twins, triplets, etc.) counts as only one delivery.

EDC:

Estimated Date of Confinement (EDC) or the due date is the calculated birthdate of the infant using the first day of the patient's last menstrual period. Charts or "OB wheels" can be used for the calculation. Write in the month/day/year.

Provider Name:

Write in the name of the physician or certified nurse midwife in charge of the patients overall OB care.

Case Coordinator:

Write in the full name and title. Example: Sarah Smart, CPHW

Provider Signature:

It is recommended that the physician sign the Individualized Care Plan to comply with CPSP regulations that all services are provided by or under the personal supervision of a physician. (Title 22, CCR, Section 51179)

Date:

Write in the date that the physician reviewed the Individualized Care Plan.

Column 1

Date:

Write in the date when the problem is identified whether at the initial assessment, reassessment, or a follow-up visit.

Strengths Identified:

Write in the patient's strengths that can help change the particular problem(s) or issue(s) identified at this visit. Strengths need to be matched to specific problems/risks (eg. problem: low education; strength: patient motivated to go back to school.)

Column 2

Identified Problem/Risk/Concern:

Write in all problems, risks, and concerns related to obstetrical, health education, nutrition, and psychosocial issues. Problems/risks are the shaded items that are found on the prenatal combined assessment. Number the problems using the same number of the question from the prenatal combined assessment. This column should include concerns that the patient wants addressed at this visit as well as issues identified by the CPSP Support Services staff. List all risk conditions that require follow-up by the support services and medical staff. **Do not** include issues that have been adequately addressed with interventions noted in the Prenatal Combined Assessment/Reassessment Tool itself. Use all the space you need to adequately document the problem/risk/concern. Refer to Appendix 2 for a sample list of obstetrical, health education, nutrition, and psychosocial problem/risk/concern(s).

Goal/Timeframe:

Each identified problem on the ICP needs to have a goal. This is the status or outcome to be achieved by the plan of action (intervention) for addressing the problem/need/risk. The projected length of time must be identified by which goals will be achieved (eg. Stabilize blood sugar level by next visit).

Column 3

Teaching/Counseling/Referral(s)

Refer to clinic CPSP protocols. Look up the number of the risk identified in the CPSP protocols. Write in all specific actions being performed to remedy the problem/ risk/ concern(s). Make sure the patient agrees with proposed interventions. These actions are based on advice, counseling, resources, and referrals provided by the staff to the patient. If patient is unwilling to follow the plan provided, document your efforts. The referrals to other professionals (RD, SW, etc.) or programs (smoking cessation program, alcohol/drug services, male involvement program, etc.) should be made in accordance with practice protocols or provider recommendation. Use short sentences and do not rewrite the problem.

Column 4 & 5

Follow-up/Reassessment Date - Outcome/Plan

Write in the date at the top of the box. Restate the problem with the respective number assigned in column 2. At the follow -up antepartum visit/reassessment, record patient's progress towards resolving the problem. Recheck the previous plan and comment on results obtained. If goals were not achieved, modify the plan and record new interventions. If the problem continues past column 5, rewrite it on an additional care plan sheet. If problem/ risk/concern (s) has been resolved, write a short note and then "resolved." A sample of an Individualized Care Plan is as follows:

Patient: Patty Preggers Gravida: 1 Para: 0 EDC: May 1, 2009

Provider Name: Dr Le Bron Case Coordinator: Sarah Smart, CPHW

Provider Signature: J. Le Bron, MD Date: 2/08/09

Date: 12/20/08 **Strengths Identified**: Motivated to see dentist	**Identified Problem /Risk/ Concern** **#30**. Has not been to dentist within past year because of lack of insurance Goal: Will go to dentist by next prenatal visit	**Teaching/ Counseling/ Referral** -CPHW reviewed /discussed STT HE p. 47 "Oral health during Pregnancy". - CPHW referred pt to dentist (denti-cal provider) HAPPY DENTAL (323)2221111	**Follow-up Reassessment Date-Outcome/Plan** 2/08/09 -Pt did not go to dentist appt because she states that she didn't feel well. Pt will go to dentist by next prenatal appt.	**Follow-up Reassessment Date-Outcome/Plan** 4/26/09 - Pt went to dentist appt 3/9/09 and states that she has no cavities -Problem resolved
Date: 12/20/08 **Strengths Identified**: -willing to discuss problems in relationship - willing to provide safe environment for self/baby	**#102** Feels threatened by boyfriend Goal: Pt will feel safe immediately	-CPHW informed pt of limits of confidentiality -CPHW reviewed/ discussed STT Psych p. 53-55 "Spouse/Partner abuse" -CPHW referred pt to SW, Wilma Ward, (323) 8675309 scheduled appt 12/30/08 -CPHW informed MD. -referred to Women's shelter (323) 445-5694 -referred to domestic violence hotline (800) 456-1111	-Pt met with SW (12/30/08) See SW notes. - Pt states broke up with boyfriend last month/feeling okay & safe. Denies seeing boyfriend	-Pt states she no longer has contact with boyfriend -Problem resolved
Date: 12/20/08 **Strengths Identified**: Encouraged to learn about breastfeeding Will @ least try to breastfeed	**#89** Plan to breast feed/formula feed because will return to work in 6 weeks. Goal: To understand benefits of exclusively breastfeeding by next prenatal visit	- CPHW reviewed/discussed STT HE p. 99-100"Infant Feeding Decision making" - CPHW reviewed/discussed STT Nutrition" How to get Started Making plenty of Milk" - CPHW reviewed Pt concerns related to return to work (I. E Breast pumps)	- Pt considering exclusively breastfeeding but is worried about milk supply - CPHW enc. Pt to attend WIC breastfeeding classes; WIC (323) 3124444	-Pt agrees to exclusively breastfeed for at least first 4 weeks. -CPHW referred pt to La Leche League (800) 9999999 - CPHW to schedule return to clinic appt after pt d/c from hospital to evaluate breastfeeding

Date: 12/20/08 **Strengths Identified**: Willing to receive treatment Concerned about health & baby's health	**Identified Problem /Risk/ Concern** Lab test positive for Chlamydia Goal: To receive treatment today	**Teaching/ Counseling/ Referral** -Dr LeBron treated pt Azithromycin 1gm PO Strongly advised to tell boyfriend to come to clinic for treatment - CPHW discussed/reviewed STT HE p23-25 "STDs" - MD advised to refrain from sex for 2 weeks. Sarah Smart, CPHW	**Follow-up Reassessment Date-Outcome/Plan** -T.O.C. negative -Per pt: left msgs for boyfriend to call back but no response. -Per MD orders advised to practice safer sex. - Problem resolved Sarah Smart, CPHW	**Follow-up Reassessment Date-Outcome/Plan** -Pt states no complaints Sarah Smart, CPHW

Sample Strengths List

(Strengths must match specific risk identified from the assessment questions. Please see ICP example)

Ability to comprehend and make decisions
Ability to cope
Adequate food
Adequate shelter/ clothing
Adequate transportation
Emotionally stable
Employed
Experience/knowledge of delivery
Experience/knowledge of infant care
Experience/knowledge of parenting
Experience/knowledge of pregnancy
Financially stable
Positive compliance
Positive self-esteem
High School Education
Interest/willingness to participate in individual/group classes
Motivated- (complete with the action the patient is motivated to do)
Refrigerator/stove
Support system
Thinking of the future
Wanted/accepted/planned pregnancy

Appendix 2

Sample of Problem List

Obstetrical

Anemia/hemoglobinopathy
Blood problems
Cardiovascular disorders
Chronic renal disease
Diabetes Type 1
Diabetes Type 2
Dysplasia/GYN malignancy
Gastrointestinal disorders
Genetic risk
Gestational diabetes
Hepatitis
History of abnormal infant
History of C-Section/Uterine Surgery
History of DES exposure
History of gestational diabetes (insulin/diet controlled)
History of hospitalization(s)
History of Incompetent Cervix
History of less than 2500 gram infant
History of more than 4000 gram infant
History of neonatal death
History of preterm birth (less than 36 weeks)
History of stillbirth
HIV risk
Hypertension/chronic
Hypo/hyperthyroid
Kidney problems
Multiple gestation
Pregnancy induced hypertension
Pregnancy interval less than a year
Psychological illness
Pulmonary disease /TB
Rh hemolytic disease
Seizure disorders
STD
Uterine problems
Vaginal bleeding

Nutrition

Abnormal glucose
Anemia
Currently breast feeding
Eating disorders
Excessive wt. Gain during pregnancy
High caffeine consumption
High parity
Hypovolemia
Inadequate wt. Gain during pregnancy
Less than 3 years since first menses
Low income
Moderately overweight (more than 120% desirable wt.)
Previous obstetrical complications
Short interpregnancy interval
Substance use
Underweight (less than 90% desirable wt.)
Very overweight (more than 135% desirable wt.)

Health Education

Age less than 17 or greater than 35 years of age
Cardiovascular problems
Conflict scheduling class times
Diabetes
Economic and housing problems
Extreme anxiety or emotional problems
Low education level
Failed Appointments
Family problems/Abuse
HIV risk status
Inability to read or write or low reading level
Inability to reach decisions or comprehension difficulties
Inadequate nutritional status
Lack of social support structure
Late initiation of prenatal care
Low motivation or interest
Little or no experience with U.S. health care
Negative attitude about pregnancy
Noncompliance with medical advice
Occupational risk
Past negative experience with U.S. health care
Physical disabilities
Preterm labor
Primigravida or multi-gravida with five or more
Substance use
Transportation

Psychosocial

Eating disorders
Excessive difficulty in coping with crisis interfering with self care
Excessive worries/fears regarding body image
Excessive worries/fears related to fetus
Extreme difficulty or resistance to comply with medical recommendations
Fear of dying during labor
Fears of inability to parent
Frequent complaints for which no diagnosis can be found
History or current indication of domestic violence
Lack of resources (financial, transportation, food, clothing, shelter)
Pregnancy complicated by detection of fetal anomaly
Previous pregnancy loss
Previous psychological history of depression, suicide, psychosis
Rejection or denial of pregnancy
Relationship problems or absence of a support person
Severe emotional problems
Unrealistic positive or negative feelings about pregnancy/motherhood/parenthood