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						

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: o Less than 12 years ↙ o 12-17 years ↙ o 18-34 years o 35 years or older
2. Are you: o Married o Single o Divorced/Separated o Widowed o 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? o Yes o No
5. Years of education completed: o 0-8 years o 9-11 years o 12-16 years o 16+ years
6. What language do you prefer to speak: o English o Spanish o Other: _____
7. What language do you prefer to read: o English o Spanish o Other: _____
8. Which of the following best describes how you read:
   o Like to read and read often o Can read, but read slowly or not very often o Do not read
9. Father of baby: (name) _____ His preferred language: _____ Education: _____ Age: _____
10. Was this a planned pregnancy? o Yes oNo
11. How do you feel about being pregnant now?
    0-13 wks: o Good o Troubled, please explain: _____
    14-27 wks: o Good o Troubled, please explain: _____
    28-40 wks: o Good o Troubled, please explain: _____
12. Are you considering (circle)adoption/abortion? o No o If Yes, Do you need information/referrals? oNo 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? O Yes - type & hr/week: _____ Cal Learn? O Yes ONo

b) Do you plan to work or go to school while you are pregnant? O Yes - type: _____ How long?____ ONo

c) Do you plan to return to work or go to school after the baby is born? O Yes type: _____ ONo

15. Will the father of the baby provide financial support to you and/or the baby? O Yes O 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	O	O	O	O	O	O	
b. Food Stamps	O	O	O	O	O	O	
c. AFDC/TANF	O	O	O	O	O	O	
d. Emergency Food Assistance	O	O	O	O	O	O	
e. Pregnancy-related disability insurance benefits	O	O	O	O	O	O	
f. Other:_____	O	O	O	O	O	O	

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	O	O	O	O	O	O
Food	O	O	O	O	O	O

Housing

18. What type of housing do you currently live in? O House O Apartment O Trailer Park O Public Housing

O Hotel/Motel O Farm Worker Camp O Emergency Shelter O Car O Other: _____

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

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

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

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

_____

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

O No 0-13 wks, please explain: _____

O No 14-27 wks, please explain: _____

O No 28-40 wks, please explain: _____

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

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

O If Yes, please _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Transportation

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

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

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

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

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

30. Have you been to a dentist in the last year? o Yes o No Any dental problems? o No o 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? o No o Yes, what kind? _____ How often? Minutes/day _____ days/week _____

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

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

34. Are you exposed to second-hand smoke? ↙ at home? o No o Yes at work? o No o 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?	o No	o Yes,	_____
14-27 wks: (circle)	At work – home – hobbies?	o No	o Yes,	_____
28-40 wks: (circle)	At work – home – hobbies?	o No	o Yes,	_____

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

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

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

o None 0-13 weeks o None 14-27 weeks o 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?

o Yes, 0-13 weeks: _____

_____

o Yes, 14-27 weeks: _____

_____

o 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? o No o Yes, how? _____

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

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

Have you tried to quit? o Yes o 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?	o Yes	o No	o Unsure	o Yes	o No	o Unsure
When you first come home with the baby?	o Yes	o No	o Unsure	o Yes	o No	o Unsure

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

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

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

44. Do you have any traditions, customs or religious beliefs about pregnancy? oNo o If Yes, please explain: _____

_____

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

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

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

46. Are you scheduled for any tests?

14-27 wks: o No o If Yes, what: _____

28-40 wks: o No o If Yes, what: _____

Do you have any questions? o No o 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) ↙	O	O	O
Diarrhea ↙	O	O	O
Constipation ↙	O	O	O
Nausea/vomiting ↙	O	O	O
Leg cramps ↙	O	O	O
Hemorrhoids	O	O	O
Heartburn	O	O	O
Vaginal Bleeding	O	O	O
Varicose veins	O	O	O
Headaches	O	O	O
Backaches	O	O	O
Abdominal cramping/contractions	O	O	O

Other: _____ Other: _____ Other: _____

48. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive this time?
O N/A O No O 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: ONo O Undecided If Yes, O what method?

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

28-40 wks: O No O Undecided If Yes, O 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? O No O If Yes, please explain: _____

_____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

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

28-40 weeks: O No O 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: O No (Refer to OB provider)

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

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

O 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 E = Explained verbally V = Video shown
W = Written material provided S = Visual aids shown I = Interpreter used

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

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

57. Will someone be able to attend classes with you? O No O 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? O No O Yes: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Nutrition - A copy of this page should be sent with the client to WIC **Date:** _____

Anthropometric: EDC: _____ WKS GA: ____ Height: _____ Current weight: ____

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

Recommended weight gain during pregnancy (check one)

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

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

O Adequate O Inadequate O Excessive O Weight loss O 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. O None relevant 65. O Age 17 or less (#1) 66. O Pregnancy interval < 1 yr.

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

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

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

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

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

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

Present: _____

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

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

Dietary:

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

O Constipation O Leg cramps O Other: _____

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

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

80. a) Number of meals/day : _____ b) meals often skipped? O No O 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? O No O Yes b) refrigerator? O No O

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

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

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

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

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

O Present: _____ O Past: _____

87. Currently use? (#37) O None O Prenatal vitamins O Iron pills O Other vitamins/minerals: _____

O Herbal remedies: O Antacids OLaxatives O Other medicines: _____

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

Why did you stop? _____

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

90. **Nutrition Assessment Summary** O 24 hour recall O 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		+ -					

O Referred to Registered Dietitian

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

Completed by: _____

Title: _____ Minutes: _____

Facility: _____ Telephone: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

DIETARY INTAKE EVALUATION **(Assessment of the Perinatal Food Frequency Questionnaire)**

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**: O Yes O No

c) **Excessive:** O Caffeine (#38)
O 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:** O Yes O No

c) **Excessive:** O Caffeine (#38)
O Referred to Registered Dietitian

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

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

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

O Adequate Ketones: - +

O Inadequate Blood drawn: date: _____

O Excessive Hgb: ___ Hct: ___ MCV: ___

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

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

Net wt. _____ (61) Protein: - +

O Adequate Ketones: - +

O Inadequate Blood drawn: date: _____

O Excessive Glucose____ Hgb: ___Hct: ___ MCV: ___

91. O 3 Hr GTT: Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 Hr: _____ O 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: O No O If Yes, please explain: _____

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

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

14-27 wks: O No

O If Yes, how: O Eat more: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

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

28-40 wks: O No O If Yes, how: O Eat more: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

O 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	O	O	O
Divorce/separation	O	O	O
Recent death	O	O	O
Illness (TB, cancer, abn. pap smear)	O	O	O
Unemployment	O	O	O
Immigration	O	O	O
Legal	O	O	O
Probation/parole	O	O	O
Child Protective Services	O	O	O

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? O No

O Very often O Often O Sometimes O Rarely O Never

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

O If Yes, when and why? _____

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

O Yes Have you ever been hospitalized for emotional problems? O What year? _____ O 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? O No O If Yes, does this create problems for you?

O No O If Yes, Please explain: _____

102. Do you ever feel afraid of, or threatened by your partner? O No O 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? ↙ O No
O 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: O No O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

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

28-40 wks: O No O 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? ↙ O No O If Yes, by whom (circle all that apply)

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

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

28-40 wks: O No O 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? ↙ O No
O If Yes, please explain: _____

107. Would you feel comfortable talking to a counselor if you had a problem? O No O 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.: _____

Instructions For Assessment of Prenatal Weight Gain

1. Find the Woman's Weight Category

- Measure her height without shoes.

- Ask the woman her weight before pregnancy (*known* as *pre-pregnancy weight*). If she does not know her pre-pregnancy weight, refer to health care provider and /or calculate the pre-pregnancy weight (see separate instructions).

- Find the woman's height on Table 1 and follow across the row to find her pre-pregnancy weight.

- The title of the column with her pre-pregnancy weight tells you her **weight category** *and also the woman's "Body Mass Index"* ***(BMI) range.***

  Example:
  A woman is 5 feet 2 inches tall. She weighed 145 pounds before pregnancy.
  Her **weight category** is Overweight . . . Her **BMI range** = 25-29.9.

2. Find the Recommended Range and Rate of Weight Gain

- Find the Recommended Weight Gain Range for her weight category on Table 2.

- Research has shown that there is insufficient data to recommend rate of weight gain for the 1st trimester.

- Find the recommended 2nd/3rd trimester rate of gain per month for her weight category.

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

3. Find the Right Weight Gain Grid

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

- Choose the grid that matches her weight category. *There are* ***four*** *weight gain grids:* Underweight, Normal Weight, Overweight, and Obese**.** Document the pre-pregnancy weight and height on the correct grid.

- **The Weight Gain Grid:**
  - The ***horizontal zero line*** starts at conception.
  - The ***vertical zero line*** represents the woman's weight before pregnancy.
  - Each horizontal line above the zero represents one pound *gained.*
  - Each horizontal line below the zero represents one pound *lost.*
  - Each vertical line represents one more week into the pregnancy (gestational age).

4. Plot the Weight Gain Grid

- **Note:** Record the woman's pre-pregnancy weight on the appropriate weight grid.

- If she does not know her pre-pregnancy weight, document the weight that was estimated or calculated.

- Take the woman's weight today and substract it from her pre-pregnant weight. This number equals the number of pounds she has gained (+) or lost (-).

  Example:
  A woman, 5 feet 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 of 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.

  -

- Plot weight gain at **each prenatal** visit. ***Always subtract the pre-pregnant weight from today's weight***.

- Show the woman where her weight is on the grid. Discuss her weight gain progress.

5. What the Weight Gain Grid Tells You

- The weight gain grid 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 and counseling.

- When a woman's gain is outside the recommended range, assess factors that may affect her weight gain. See "*Low Weight Gain"* and "*High Weight Gain"* in the Nutrition section of Steps to Take Guidelines.

  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 they are eating a nutritious diet. Other women may be eating too little or too much. It is important to find out what the woman is eating. Follow the guidelines for the Perinatal Food Frequency Questionnaire (PFFQ).
  (A 24-hour food recall is also an acceptable dietary assessment tool, but is not recommended unless the assessor has received adequate training.)

Steps to Take for Appropriate Weight Gain

- **If the woman is gaining above or below the recommended range, complete the Perinatal Food Frequency Questionnaire (or 24-Hour Food Recall) monthly.**

  Emphasize the Daily Food Guide for Pregnancy whether or not the pregnancy weight gain fits the recommended weight gain grid.

- **If she is not eating enough or eating too much** in any of the food groups, discuss with the woman the changes she needs to make in her diet.

  Make a plan together that will bring about positive changes.

- **If her weight gain is within the recommended range**, assess her diet.

  If her diet is fine, congratulate the woman and encourage her to continue eating well.

  Review her diet intake each month and her weight at **each prenatal** visit.

- **If her weight gain is below the recommended range**, review "*Low Weight Gain*" in the Nutrition section of Steps to Take Guidelines.

  Even if the woman is not eating enough of certain foods, look for other factors which may also explain the low weight gain.

- **If her weight gain is above the recommended range**, review "*High Weight Gain*" in the Nutrition section of Steps to Take Guidelines.

  Do not restrict the diets of women who are gaining extra weight when they consume low fat foods within the recommended number of food groups.

  Even if the woman is eating too much of certain foods, look for other factors which may also explain her excess weight gain.

- **Continue to monitor weight gain at each prenatal visit.**

Reference:
Adapted from Steps to Take, Comprehensive Perinatal Services Program – Program Guidelines for Enhanced Health Education, Nutrition, and Psychosocial Services, Steps to Take Guidelines, 1997 Edition, CDHS.

Table 1: Weight Categories for Women According to Height and Pre pregnancy Weight *

Height	Under Weight **(BMI - < 18.5)**	Normal Weight **(BMI 18.5 – 24.9)**	OverWeight **(BMI 25-29.9)**	Obese Weight **(≥ 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’ 0”	< 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 ’0”	<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

Table 2: Recommended Range and Rate of Weight Gain

* Recommended - Weight Gain Range Twins	Underweight 28 - 40 lbs. N / A	Normal Weight 25 - 35 lbs. 37–54 lbs.	Overweight 15 – 25 lbs. 31–50 lbs	Obese 11 – 20 25-42 lbs.
** Recommended Rate of Weight Gain /mo.				
*** 1st Trimester	------	------	------	------
2nd /3rd Trimester	4lbs.ormore	3-4 lbs.	about 2 lbs.	varies

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

** - Steps to Take, Comprehensive Perinatal Services– Program Guidelines for Enhanced Health Education, Nutrition, and Psychosocial Services, Step to Take Guidelines, 1997 Edition, CDHS.

*** - Research to date concludes that there is insufficient data for recommendation for rate of weight for the 1st trimester.

INSTRUCTIONS
WHEN PRE-PREGNANCY WEIGHT IS NOT KNOWN

At the first visit:

1. Estimate the woman's pre-pregnancy status (*underweight, normal weight, overweight or obese weight*) by considering her current height and weight. If uncertain, consider her to be within the normal range.

2. Determine the week of gestation at the time of the current weight.

3. Place a dot on the grid where the line representing the week of gestation crosses the lower line of the weight gain range estimated to be appropriate for the woman.

4. Subtract the number of pounds represented by the line at the dot from the current weight to determine an estimated pre-pregnancy weight. Record this estimated pre-pregnancy weight on the appropriate weight gain grid, noting that it is "*estimated"*, or "*calculated*".

   Example:
   Pre-pregnancy Weight = Est. 150 lbs. - **or** Pre-pregnancy Weight = Calc.150 lbs.

When future weight measurements are available:

1. Determine the number of pounds gained or lost by comparing the current weight with the estimated pre-pregnancy weight.

2. Determine the week of gestation on the date of the current weight.

3. Place a dot on the grid where the line representing the number of pounds gained or lost crossed the line representing the week of gestation.

4. Compare the change in weight between measurements with the gain expected for the estimated pre-pregnancy status (*underweight, normal weight, overweight, or obese*).

5. Consider the results of this assessment with the results of the dietary and clinical (physical/medical) assessment to determine appropriate recommendations.

Reference:
Adapted from Maternal and Child Health Branch, WIC Supplemental Food Branch, California State Department of Health Services, Prenatal Weight Gain Grid, June 1991.

Rev. 6/9/10

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:***

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."

1. 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.

2. 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.

Incorporating PFFQ Information Into
Initial Combined Assessment/Reassessment Tool

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.

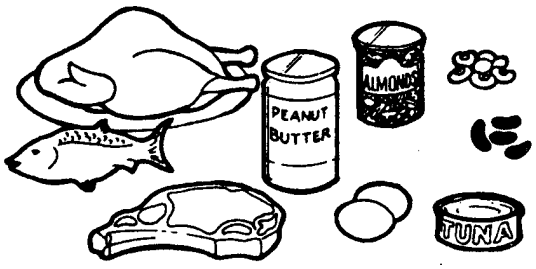
Please check one:
____Initial Assessment ____3rd Trimester Reassessment
____2nd Trimester Reassessment ____Postpartum Assessment

Client Name:
I.D. Number:

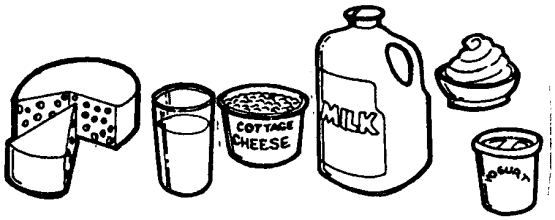
PERINATAL FOOD FREQUENCY QUESTIONNAIRE
(PFFQ)

(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.
:

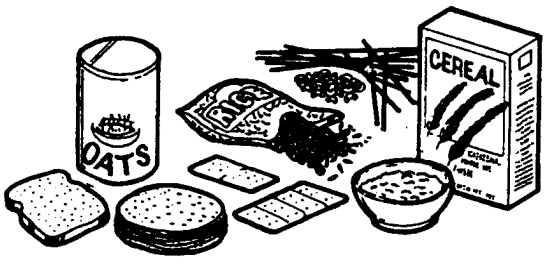
Group 1	Daily	Weekly
meat/carne		
chicken/pollo		
fish/pescado		
shellfish/mariscos		
Eggs/huevos		
*beans/frijoles		
peanut butter/crema de cacahuate		
Subtotals:	x7=	+
(21)		**Total Points:**



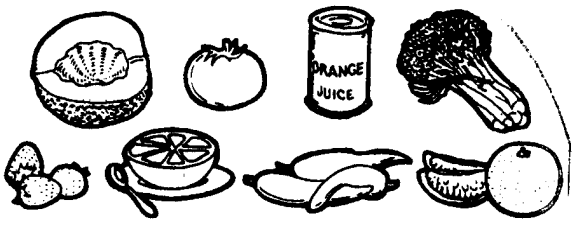
Group 2	Daily	Weekly
milk/leche		
cheese/queso		
yogurt/yogur		
Subtotals:	x7=	+
(21)		**Total Points:**



Group 3	Daily	Weekly
Bread/pan(1 slice)		
tortilla (1)		
cooked cereal/cereal, cocida		
dry cereal/cereal, seca		
rice/arroz		
pasta		
Subtotals:	x7=	+
(49)		**Total Points:**



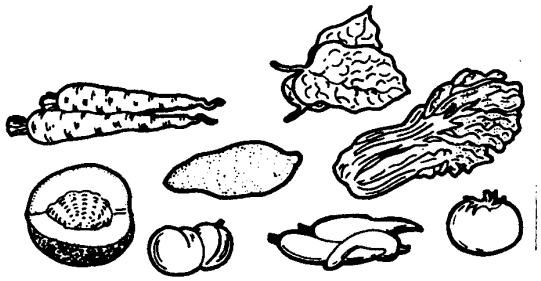
Group 4	Daily	Weekly
*orange/naranja		
*orange juice/jugo de naranja		
*tomato/tomate		
cabbage/col repollo		
*broccoli/brocoli		
*cauliflower/coliflor		
Subtotals:	x7=	+
(7)		**Total Points:**



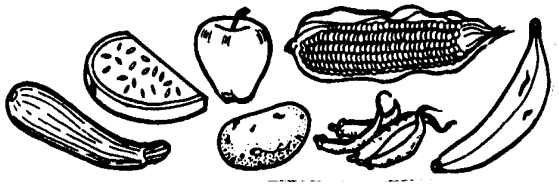
*-Adapted for LAC/DHS-CPSP Trainings

Name: I.D.

Group 5	Daily	Weekly
*spinache/greens espinaca/hojas de verde		
sweet potato/camote		
carrots/zanahoria		
cantaloupe/melon		
Mango		
Subtotals:	x7=	+
(7)		**Total Points:**



Group 6	Daily	Weekly
apple/manzana		
banana/platano		
pineapple juice/jugo de pina		
corn/elote		
lettuce/lechuga		
potatoes (white)/ papas (blancas		
zucchini/calabazita		
other fruits & vegetables/otras frutas y verduras		
Subtotals:	x7=	+
(21)		**Total Points:**



Other Foods	Daily	Weekly
fried foods /comidas fritas		
Butter/mantequilla		
▲ margarine/ margarina		
sour cream/crema agria		
▲ mayonnaise/ mayonesa		
▲ salad dressing/ salsa para ensalada		
▲ vegetable oil/ aceite vegetal		
▲ avocado/ aguacate		
chips/papitas		
Donuts		
candy/ carmelo/chocolate		
Soda		
other sugar drinks/ bebidas con azucar		
other sweets/otros dulces		

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

*Daily Food Guide for Pregnant/Breastfeeding Women (All Ages) 4B

Food Groups	One Serving Equals		Recommended Minimum Servings
Protein Foods Provide protein, iron, zinc, and B-vitamins for growth of muscles, bone, blood, and nerves. Vegetable protein provides fiber to prevent constipation.	**Animal Protein:** 2-3oz Cooked chicken, turkey, lean beef, lamb, pork, or fish. 2 Eggs 2 Fish sticks or hot dogs 2 slices luncheon meat ¼ cup canned tuna or other canned fish	**Vegetable Protein:** ½ cup cooked dry beans, lentils or split peas 3 oz Tofu ¼ cup nuts or seeds 2 tbsp. peanut butter	**3** Include one serving of vegetable protein daily.
Milk Products Provide protein and calcium to build strong bones, teeth, healthy nerves and muscles, and to promote normal blood clotting.	8 oz milk or yogurt 1 cup milk shake 1½ cup cream soup (made with milk) 1½ oz or 1/3 cup grated cheese (like cheddar, Monterey, mozzarella, or Swiss)	1½ -2 slices pre-sliced American cheese 4 tbsp. parmesan cheese 2 cups cottage cheese 1 cup pudding, custard or flan 1½ cups ice milk, ice cream, or frozen yogurt	**3**
Breads, Cereals & Grains Provide carbohydrates and vitamins for energy and healthy nerves. Also provide iron for healthy blood and fiber to prevent constipation.	1 slice bread or dinner roll ½ bun, bagel, English muffin or pita 1 small tortilla ¾ cup dry cereal ½ cup cooked cereal or granola	½ cup rice, noodles or spaghetti ¼ cup wheat germ 1 4-inch pancake or waffle 1 small muffin 8 medium crackers 4 graham cracker squares 3 cups popcorn	**7** Four servings of whole-grain products daily
Vitamin C-Rich Fruits and Vegetables Provide vitamin C to prevent infection and to promote healing and iron absorption. Also provide fiber to prevent constipation.	6 oz orange, grapefruit, or fruit juice enriched with vitamin C 6 oz tomato juice or vegetable juice cocktail 1 orange, kiwi, mango ½ grapefruit, cantaloupe ½ cup papaya 2 tangerines	½ cup strawberries ½ cup cooked or 1 cup raw cabbage ½ broccoli, Brussels sprouts, or cauliflower, snow peas, sweet peppers, or tomato puree 2 tomatoes	**1**
Vitamin A-rich Fruits and Vegetables Provide beta-carotene and vitamin A to prevent infection and promote wound healing and night vision. Also provide fiber to prevent constipation.	6 oz apricot nectar, or vegetable juice cocktail 3 raw or ¼ cup dried apricots ¼ cantaloupe or mango 1 small or ½ cup sliced carrots 2 tomatoes	½ cup cooked or 1 cup raw spinach ½ cup cooked greens (beet, chard, collards, dandelion, kale, mustard) ½ cup pumpkin, sweet potato, winter squash, or yams.	**1**
Other Fruits & Vegetables Provide carbohydrates for energy and fiber to prevent constipation.	6 oz fruit juice (if not listed above) 1 medium or ½ cup sliced fruit (apple, banana, peach, pear) ½ cup berries (other than strawberries) ½ cup cherries, grapes, pineapple or watermelon	¼ cup dried fruit ½ cup sliced vegetable (asparagus, beets, green beans, celery, corn, eggplant, mushrooms, onion, peas, potato, summer squash, zucchini) ½ artichoke 1 cup lettuce	**3**
Unsaturated Fats Provide vitamin E to protect tissue.	1/8 medium avocado 1 tsp. margarine, mayonnaise or vegetable oil	2 tsp. salad dressing (mayonnaise-base) 1 tbsp. salad dressing (oil based)	**3**

Note: The Daily Food Guide for Women may not provide all the calories you require. The best way to increase your intake is to include more than the minimum servings recommended.

*-Adapted for LAC/DHS-CPSP Trainings

CPSP PROBLEM LIST

Patient Name**:** _____ Date of Birth**:** _____

Question #	Problems identified in Initial Assessment	Ranking Order	Resolved Column (Date)
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____

Patient Signature: _____ CPHW Signature: _____Date: _____

Question #	Problems identified in 2nd Assessment	Ranking Order	Resolved Column (Date)
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____

Patient Signature: _____ CPHW Signature: _____Date: _____

Question #	Problems identified in 3rd Assessment	Ranking Order	Resolved Column (Date)
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____

Patient Signature: _____ CPHW Signature: _____Date: _____

Question #	Problems identified in Postpartum	Ranking Order	Resolved Column (Date)
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____
#_____	_____	_____	_____

Patient Signature: _____ CPHW Signature: _____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 <u>Identified</u>:** Willing to receive treatment Concerned about health & baby's health	**Identified Problem /Risk/ Concern** Lab test positive for Chlamydia <u>Goal:</u> 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-<u>Outcome/Plan</u>** -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-<u>Outcome/Plan</u>** -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

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

Individualized Care Plan (ICP)

Patient:_____ Gravida: ____ Para:_____ EDC:_____

Provider Name: _____Case Coordinator Name: _____

Provider's Signature:_____ Date: _____

Date: _____ Strengths Identified:	Identified Problem/ Risk/Concern _____ Goal:	Teaching/ Counseling/ Referral _____	Follow-up Reassessment Date- Outcome/Plan	Follow-up Reassessment Date- Outcome/Plan
Date: _____ Strengths Identified:	Goal:			

First initial, last name, title and date required with every entry.
May be used in conjunction with, or without a standardized prenatal/postpartum education/services checklist.
Address obstetrical, nutrition, psychosocial, and health education problems/needs.

Pt. name:
DOB:
Health Plan:
I.D.#:

Patient: _____ I.D. # : _____
Provider Signature: _____

Date: _____ Strengths Identified:__	Identified Problem /Risk/Concern _____ Goal:	Teaching/ Counseling/ Referral _____	Follow-up Reassessment Date- Outcome/Plan	Follow-up Reassessment Date- Outcome/Plan
Date: _____ Strengths Identified:__	Identified Problem /Risk/Concern _____ Goal:	Teaching/ Counseling/ Referral _____	Follow-up Reassessment Date- Outcome/Plan	Follow-up Reassessment Date- Outcome/Plan

First initial, last name, title and date required with every entry.
May be used in conjunction with, or without a standardized prenatal/postpartum education/services checklist.
Address obstetrical, nutrition, psychosocial, and health education problems/needs.

Pt. name:
DOB:
Health Plan:
I.D.#:

Individualized Care Plan

PROCEDURE FOR INDIVIDUALIZED CARE PLAN (ICP) EVALUATION TOOL

Purpose: To evaluate the quality of the CPSP Individualized Care Plan (ICP) by determining that: 1) required ICP components are completed; and 2) goals and interventions are appropriate to improve maternal/infant health.

Procedure: Each reviewer will use the ICP Evaluation Tool to review assessments, reassessments, and care plans, preferably for postpartum patients (to give a complete view of the services provided throughout the perinatal period.

During the review process, distinguish between what is written and what really happens by interviewing staff when necessary. Excellent service may be poorly documented; perfect documentation does not ensure that services were provided as stated. Assign a score of 0, 1, or 2 according to documentation, but note discrepancies between actual services (as reported by staff) and documentation in "Findings."

INDICATORS:

1. **Case Coordinator identified for each client –** Name of case coordinator appears on ICP or elsewhere on patient record.

2. **Patient strengths –** List all strengths and/or support the client has available to assist her through the pregnancy. Depending on ICP being used, strengths may need to be matched to specific risks/problems, e.g. problem = no knowledge of pregnancy or newborn care; strength = completed high school, likes to read, etc.

3. **Documentation of risk conditions/problems identified during initial OB & CPSP assessments** - Review ICP for problems/needs/risk conditions (if any) for each CPSP component: obstetric, nutrition, health education and psychosocial and compare to information found on OB medical record and CPSP Initial Assessment. It is expected that all problems are on the ICP; however, in cases where a patient has numerous problems, it may be more practical to list only the significant problems on the initial ICP and "hold" the other problems on a problem list until they can be added to the ICP or are resolved.

   If no problems are identified during the assessment for a specific discipline, e.g. psychosocial, note in the findings if there is any documentation on the ICP or elsewhere stating, for example, "no p/s problems."

4. **Proposed interventions per protocol** - CPSP providers are responsible for providing individual or group interventions for problems identified during assessments/reassessments. Interventions should be consistent with site protocols and appropriate for the individual client and problem being addressed. In other words, are interventions likely to improve outcome; or are they done for every patient, regardless of need, e.g. all patients get smoking cessation/substance use class, even if they have no identified risk.

5. **Goal/Desired Outcome** – 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 (e.g., stabilize blood sugar level by next visit).

6. **Time frame** - projected length of time (or date) by which goals (outcome objectives) will be achieved (e.g. 6 weeks or 12/10/06).

7. **Parties Responsible** - staff person (e.g., physician, RN, RD, CPHW) responsible for carrying out each proposed intervention.

8. **Used by all members of care team** – since CPSP is a multidisciplinary program and the ICP is the care coordination document, it is essential that all members of the care plan contribute to the plan, or at least review the content. This will be evident if ICP documentation is done by various staff members or based on information obtained during staff interview.

9. **Appropriate referrals made and outcome noted** – medical, health education, nutrition, and psychosocial referrals are made in accordance with site protocols. Documentation includes date referral was made, appointment kept (or reason patient did not comply), and notes from consultant or referral agency as to outcome of referral and recommended f/u.

10. **ICP updated at least once each trimester** – previously identified problems/risks and interventions are evaluated and modified, as needed, based on progress toward achieving goal. New problems identified on 2nd & 3rd trimester reassessments are added to ICP, including information as noted in #4-8 above. ICP may need to be updated more frequently than once a trimester, depending on time frame listed for each problem.

11. **ICP updated in postpartum period** – progress toward goals for previously identified problems are evaluated and ICP updated as needed. New problems identified during postpartum assessment are added to ICP. It is recommended that the postpartum care plan include interconception care planning.

12. **Client orientation** – documentation of all orientation topics covered or reference to standardized orientation protocols.

13. **Weight gain grid plotted each visit** – use of appropriate weight gain grid, based on accurate determination of pregravida weight; patient's weight at **each OB visit** should be plotted correctly.

14. **Food Intake –** required component of each nutrition assessment, trimester reassessment, and postpartum assessment. Either a Perinatal Food Frequency Questionnaire (PFFQ) or 24-hour food recall should be completed at least each trimester and postpartum and must be kept on the chart.

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? oYes Date:

oIf No, when scheduled? _____

23. Any health problems since delivery? oYes oNo

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: o WIC Date Enrolled: _____

o Food Stamps o Emergency Food o AFDC

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

28. **Infant**

Method of Feeding: o Breast o Bottle o Breast & Bottle # Wet diapers/day? ____

Type of Formula: ____ With Iron? o Yes o No ____ oz.. ____ times/day

Psycho-Social

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

Health Education

35. If breast feeding:
    Do you have enough milk? OYes ONo
    * Do you supplement with formula? OYes ONo
    Does your baby take the breast easily? OYes ONo
    Are your nipples cracked and/or sore? OYes ONo
    Do you have any questions about breast feeding? OYes ONo
36. Do you have any questions about mixing or feeding formula? OYes ONo
37. Do you have any questions about your baby's health? OYes ONo
    If "Yes", please explain: _____
38. Do you have any questions about your baby's safety? OYes ONo
    If "Yes", please explain: _____
39. Are you using, or planning to use, any method of birth control? OYes ONo
    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:

O	Birth Control	O	Infant Feeding	O	Infant Care	O	Infant Safety	O	_____
O	_____	O	_____	O	_____	O	_____	O	_____

Summary:

Date:_____ Interviewer:_____ Title_____ Minutes Spent:____

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

DUTIES OF THE CASE COORDINATOR

The Case Coordinator works closely with members of the health care team and the client in the development and implementation of the care plan.

The Case Coordinator:

1. Acts as liaison between the client and the team to promote effective communication.

2. Maintains close contact with the client throughout pregnancy and the postpartum period.

3. Coordinates development of a complete individualized care plan.

4. Modifies the care plan as the client's condition changes.

5. Assists the client with practical arrangements such as: transportation, translation needs and assistance with tests, referrals and special appointments.

6. Oversees the completion of all recommendations made on the care plan.

7. Ensures that results of tests and referrals are given to appropriate team members and are recorded in the client's chart.

8. Keeps track of the client's attendance at appointments, identifies the reason for a missed appointment, an assists the client with making a new appointment.

9. Ensures communication between team members and encourages care conferences to evaluate the patient's progress and quality of care given.

10. Is available as a contact for problems and questions. Assists the client in problem-solving.

11. Oversees the client's chart for completeness of documentation of care.

12. Ensures provision of appropriate copies of the prenatal record at the hospital during the intra-partum period. Ensures provision of intra-partum records at the outpatient site during the post-partum visits.

COMPREHENSIVE PERINATAL SERVICES PROGRAM

CASE COORDINATION

I. What Is Case Coordination?

A. The implementation of a system for planning and ensuring the provision of comprehensive perintal services to the patient

B. The formal system of record keeping and communication

C. The involvement of all aspects of patient care and all practitioners

II. What Are the Components of Case Coordination?

A. Assessments (obstetrical, nutrition, health education and psychosocial)

B. Written individualized care plan based on all assessments

C. Appropriate interventions/treatments provided according to the care plan

D. Continuous assessments of patient's status and progress relative to care plan interventions with appropriate revision of the care plan

E. Case conferences or other appropriate communication involving all team members regarding each patient's care

F. Comprehensive record system where all information relating to patient care is documented and is available to all team members

G. Record-sharing system to exchange information among providers, especially for referrals, consultations and reporting pregnancy outcome

Comprehensive Perinatal Services Practitioners:

***Practitioner Types**

Physician	(MD)	Marriage and Family Therapist	(MFT)
Certified Nurse Midwife	(CNM)	Health Educator	(HE)
Registered Nurse	(RN)	Childbirth Educator	(CE)
Nurse Practitioner	(NP)	Dietitian/Registered	(RD)
Physician Assistant	(PA)	Comprehensive Perinatal Health Worker	(CPHW)*
Social Worker	(SW)	Licensed Vocational Nurse	(LVN)

****Years of Experience**

For MD, CNM, RN, NP, PA, SW, MFCC, HE, LVN-Years of experience in Maternal and Child Health.
For CE, CPHW-Years of experience in perinatal care.
For RD/RDE-Years of experience in perinatal nutrition

Application Update Provider _____
Submitted by_____ Date____ ____
Current Medi-Cal Provider Number _____

*CPHWs must be at least 18 years of age, a high school graduate or equivalent and have at least one year of full-time paid practical experience providing perinatal care. Complete only the shaded fields below.

Practitioners:

Last Name First Middle Initial *	*Type or Specialty	CA License, Certificate, Registration Number	Expr. Date of Lic., Cert., or Reg. No. MM/DD/YY	Year Graduated * Degree and Institution/Univ. High school only for CPHWs	Medi-Cal Rendering Provider Number	**Years of Experience *	Obstetrics (applies to Physicians, CNM, NP, PA)	Supervision	Back-up	Client Orientation	Health Education	Nutrition	Psychosocial	Case Coordination	Consultant	Protocol Approval
Add:																
Delete:																

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name:_____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

		Not at all	Several Days	More than half the days	Nearly Everyday
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		Add Columns	+	+	
		TOTAL			

(Healthcare professional: For interpretation of TOTAL, please refer to instructions on tear-off pad cover

10	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
		Somewhat difficult	_____
		Very difficult	_____
		Extremely difficult	_____

_____ _____

Provider Signature Date

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

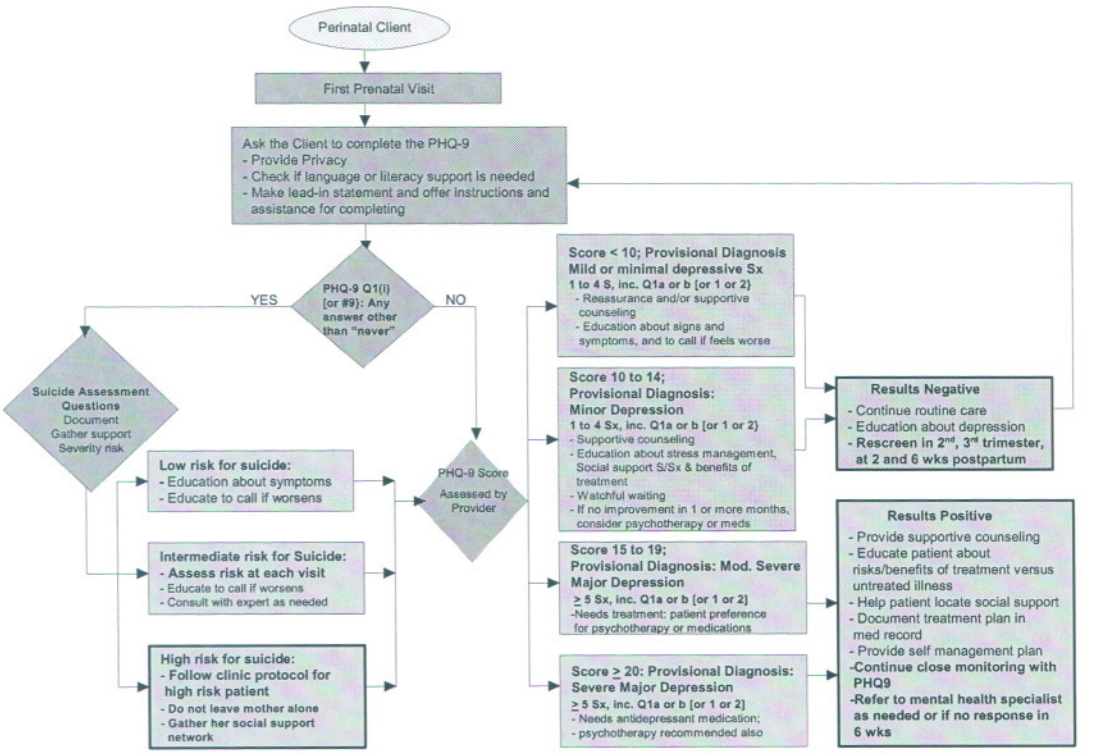
Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Example: Perinatal Depression Clinical Pathway Using the PHQ-9 Screening Tool



S/Sx - signs and Symptoms

Adapted for the Healthy Births Care Quality Collaborative from MedEd- Care Pathways at www.mededppd.org

COUNTY OF LOS ANGELES, DEPARTMENT OF MENTAL HEALTH SERVICES AREAS
ACCESS LINE 24/7: (800) 854-7771

Service Area 1 – Antelope Valley			
Antelope Valley Mental Health Services	346-A East Ave., K-6	Lancaster, CA 93535	661.723-4260
Service Area 2 - San Fernando/Santa Clarita			
Santa Clarita Valley Mental Health Services	25050 Peachland Ave., 203	Newhall, CA 91303	661.222.2800
West Valley Mental Health Services (CMC)	7623 Canoga Ave.,	Canoga Park, CA 91303	818.598.6900
San Fernando Mental Health Services	12605 Balboa Ave., 100	Granada Hills, CA 91344	818.832.2400
MacDonald Carey MHC	11631 Victory Blvd., 203	No. Hollywood, CA 91606	818.908.3855
Service Area 3 – San Gabriel Valley			
Arcadia Mental Health Service	330 E. Live Oak Ave.	Arcadia, CA 91006	626.821.5858
Service Area 4 – Metropolitan			
Hollywood Mental Health Services	1224 N. Vine St.	Los Angeles, CA 90038	323.769.6100
Northeast Mental Health Services	5321 Via Marisol Rd.	Los Angeles, CA 90042	323.478.8200
Downtown Mental Health Center	529 Maple St.	Los Angeles, CA 90013	213.460.6100
Service Area 5 –West			
Edelman Mental Health Center	11531 W. Olympic Bl.	Los Angeles, CA 90064	310.966.6500
Service Area 6 – South			
Augustus Hawkins Mental Health Center	1720 E. 120th Street	Los Angeles, CA 90058	310.668.4271
Compton Mental Health Services	931 E. Compton Bl.	Compton, CA 90221	310.668.6600
Kedren Community Mental Health	4211 S. Avalon Bl.	Los Angeles, CA 90011	323.233.0425
Latino Mental Health Center	1720 E. 120th Street	Los Angeles, CA 90059	310.668.3112
West Central Family Mental Health	3751 Stocker Street	Los Angeles, CA 90008	323.298.3680
Service Area 7 – East			
Rio Hondo Community Mental Health	17707 Studebaker Rd.	Cerritos, CA 90701	562.402.0688
American Indian Counseling Center	17707 Studebaker Rd.	Cerritos, CA 90701	562.402.0677
East Los Angeles, Mental Health	6001 Clara Street	Bell Gardens, CA	562.806.5000
Service Area 8 - Harbor			
Long Beach Asian Pacific Mental Health	1975 Long Beach Bl.	Long Beach, CA 90806	562.599.9401
Long Beach Mental Health Services	1975 Long Beach Bl.	Long Beach, CA 90805	562.599.9280
San Pedro Mental Health Services	150 W. 7th Street	San Pedro, CA 90731	310.519.6000
Coastal Asian Pacific Mental Health	14112 S. Kingsley Dr.	Gardena, CA 90247	310.217.7312
South Bay Mental Health Services	2311 W. El Segundo Blvd.	Hawthorne, CA 90250	323.241.6730
Specialized Community Programs	550 S. Vermont Ave., 6th floor	Los Angeles, CA 90020	213.738.3724