COUNTY OF LOS ANGELES PUBLIC HEALTH
Comprehensive Perinatal Services Program (CPSP)

Initial Combined Assessment (ICA)
&
Individualized Care Plan (ICP)

AGENDA

8:30 AM – 9:00 AM	Registration
9:00 AM – 9:30 AM	Welcome and Self Introductions
9:30 AM – 12:00 Noon	Development of the Individualized Care Plan o *Purpose and Definition* o *Procedure* o *Client Information* o *Explanation of Columns (1 thru 5)*

12:00 Noon PM 1:00 PM Lunch

1:00 PM – 2:00 PM	Development of the Initial Combined Assessment (ICA) o *Purpose* o *Procedures/Process* (Review CPSP Provider Handbook-Initial Assessment) o *Review Prenatal and Postpartum Questions* o *Practical Application* o *When to use Assessment/Reassessment Tool*
2:00 PM – 2:30 PM	Wrap Up: Questions & Answers/Evaluation

CPSP TRAINING

S M A R T GOALS

S pecific

M easurable

A chievable/Agreed

R ealistic/Relevant

T ime-limited

Smart goals.mw
December 23, 2009
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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.

COMPREHENSIVE PERINATAL SERVICES PROGRAM
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CPSP Web Site Address: **www.publichealth.lacounty.gov**

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

Referral Form

Patients Name:_____ Date of Referral:_____ EDD:_____

DATE OF APPOINTMENT: _____ TIME:_____

Referred to (Agency/ Consultant):_____

Address:_____

Phone Number:(_____)_____

Contact Name:_____

Reason for Referral: _____

_____

COMPLETE THIS SECTION AND RETURN TO MEDICAL PROVIDER

FAX: (_____)_____

OR EMAIL:_____
Date: _____
Findings:_____

_____

Treatment and Recommendations:_____

_____

Signature of Practitioner:

_____ Date:_____

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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: _____

Process of Applying for Food Stamps

Food Stamp Hotline
1-877-597-4777
For office nearest you

Can also call this number to ask any additional questions about the food stamp program

Seniors, individuals With disabilities And/or CalWorks recipients can request a home visit

All other individuals fill out application at office

Can have same day interview or schedule interview for another day

OR

Have application Mailed to you

Set up interview day over phone with food stamp office

Note: If you are already receiving any type of government help, like AFDC, GR, Medical, or other benefits and you are interested in receiving food stamps, your current **eligibility worker may** be able to help you with the process.

Call eligibility worker **or** EBT hotline
1-877-328-9677
for questions about EBT

Quarterly income status reports

REMEMBER to ask your eligibility worker what documents you need to take to your interview

Finger imaging And digital photo

If you qualify, you should receive an **EBT** card in the mail within **30 days** of applying

Shop with **EBT** Cards at participating supermarkets and farmers' markets

Questions Often Asked About the Food Stamp Program

What does it take to qualify?
There are three important factors that are used to help determine eligibility:

- Income
- Number of people in a household
- Legal Status

How do I apply?
You can go to the food stamp office near you and ask for an application. If you do not know where your office is, you can call the food stamp hotline at 877-597-4777. If you need help filling the application out, you can request for assistance. You will then go through an interview process where you will be asked to turn in different documentation, take fingerprints of all adults in the family, and finish the application process.

What if more than one family is living under the same roof?
Each family must prove that they purchase and prepare meals separately in order to be considered independent from the other families. In cases like these, the total amount of rent and other expenses must be provided and how much each family applying contributes.

Do I have to pay back food stamps?
No. These benefits come from the United States Department of Agriculture (USDA) to help alleviate hunger and improve the nutrition of families.

Does owning a home make me ineligible?
No. Homeowners can still qualify for food stamps. It is not counted as an additional asset.

Does owning a car make me ineligible?
No. The car rule no longer applies as of January 2004. Families can own a car and still be eligible for the food stamp program.

Do working families qualify?
Absolutely. Working families qualify as long as they meet all the requirements. Some families are under the impression that if both parents work they do not qualify, but this is a myth.

Do I qualify if I receive SSI?
No. Unfortunately, in California, money for food expenses is already included with SSI benefits.

Does everyone in the family need to be present during the interview?
No. Only the adults in the family need to be present at the time of fingerprinting.

Are family members without a Social Security Number counted as part of the household?
All people are counted in a household whether or not they have a social security number, but only those with a social security number will receive benefits.

Will receiving food stamps hurt my chances of becoming a permanent resident or citizen?

No. Programs like Food Stamps, WIC, and MediCal are not considered Public Charge by the US government, so it does not affect citizenship status, but in many cases people feel confused because they might be asked if they received food stamps by their Immigration Officer during an interview. The information given to the food stamp office is confidential and is not shared with INS or any other government agency, but the food stamp office does verify that all information given is true and correct.

Does my family qualify if we are already getting any other type of government assistance?

Yes. Individuals who have a caseworker and are interested in also receiving food stamps can request information from them. In some cases, that same worker may be able to help an individual apply for food stamps.

How can I verify my income if I get paid by cash?

In this case, the person must request a letter from their employer stating how much the employee earns per month. Have the employer put their contact information on the letter.

Can single adults receive food stamps?

Yes. Single adults are called ABAWD's or Able Bodied Adults Without Dependents. They can qualify depending on their income and legal status. If a single adult is unemployed they can receive food stamps for three months. After that they can continue to receive them, but they must prove that they are looking for employment or are part of a job training Program.

Documents You Will Need for a Food Stamp Application

The checklist on this envelope can help you get ready for your interview with a food stamp worker You do not need everything on this list. Collect only the checked items. Bring them with you to your food stamp interview.

__ Driver's license
__ Birth certificate
__ Work or school identification card
__ Health benefits identification card
__ Voter registration card
__ Utility bills
__ Rent or mortgage receipts
__ Library card with address
__ Immigration and naturalization papers
(not required if you are not eligible to receive food stamp benefits but are applying for your children who were born in the United States)
__ Pay stubs
__ Income tax forms
__ Self employment bookkeeping records
__ Bank statements

__ Benefit award letter
__ Divorce or separation decree
__ Unemployment compensation award letter
__ Court order or other legal document for child support payments
__ Canceled checks for child support payments
__ Statement from person to whom child support payments are made
__ Paid receipts for child support payments
__ Canceled checks for child/adult care payments
__ Statement from child/adult care provider
__ Medical bills
(households with elderly or disabled members only)
__ Itemized receipts for medical costs
(households with elderly or disabled members only)
__ Medicare card showing "Part B" coverage
(households with elderly or disabled members only)
__ Repayment agreement with physician
(households with elderly or disabled members only)
__ Other:

Food Stamps Make America Stronger.

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

Psycho-Social 29

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)_____

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.

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. LeBron, 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

Los Angeles County Department of Health Services
Comprehensive Perinatal Services Program (CPSP)
"ICA-ICP"
Evaluation Form

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_____

Evaluation Before "ICA-ICP Training":	Circle Your Rating				
	Inadequate		Good		Excellent
a. How comfortable do you feel providing CPSP assessments?	1	2	3	4	5
b. How comfortable you feel developing a CPSP Care Plan (ICP)?	1	2	3	4	5

1) Please rate the following components of the training:

	Poor				Excellent
1. Initial Combined Assessment (ICA) Trimester Reassessment/Postpartum	1	2	3	4	5
2. Problem/Issues List	1	2	3	4	5
3. Individual Care Plan (ICP)	1	2	3	4	5
4. Use of Protocols and "Steps To Take	1	2	3	4	5

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

3) What information did you find most useful:

_____

_____

_____

4) What information from the training did you find least helpful:

_____

_____

5) How confident do you feel about doing an assessment and individualized care plan as a result of this training:

Assessment
- [] Very Confident
- [] Confident
- [] Somewhat Confident
- [] Not Confident

Individualized Care Plan
- [] Very Confident
- [] Confident
- [] Somewhat Confident
- [] Not Confident

6) Training needs/Topics (please specify):

_____

_____

7) Your comments and recommendations are welcomed:

_____

_____