CPSP ORIENTATION CHECKLIST

Provider: _____

Patient: _____ DOB: _____ EDD: _____

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

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

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