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

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

Client Name: _____ Date of Birth: _____

Health Plan: _____ ID Number: _____

Provider: _____ Delivery Hospital: _____

Case Coordinator: _____ EDD: _____

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

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

Personal Information	**Individualized Care Plan**
1. Client age: □ Less than 12 years □ 12-17 years □ 18-34 years □ 35 years or older	Intervention/Referral: □ Child abuse report filed (if younger than 18 and abuse suspected)/date:_____ □ Reviewed/discussed □ STT FS: *Approaching Clients of Different Ages* □ STT PSY: *Teen Pregnancy and Parenting* □ Signed up for Text4Baby by texting BABY or (BEBE for Spanish) to 511411 □ Referred to Adolescent Family Life Program/date:_____ □ Referred to home visitation program/date:_____ □ Referred to social worker/date:_____ □ Referred to/date:_____ □ Discussed importance of genetic counseling (if over 35)
2. Are you: □ Married □ Single □ Living with partner □ Divorced/Separated □ In a relationship □ Widowed □ Other_____	Intervention/Referral: □ Referred to/date:_____ □ Referred to social worker/date:_____
3. How long have you lived at your current home? □ Over one year □ Under one year, previously lived:_____ □ Familiar with local area □ Not familiar with local area Place of birth:_____	Intervention/Referral: □ Reviewed/discussed STT FS: □ *Cultural Considerations* □ *Cross Cultural Communication* □ *Client's with Alternative Health Care Experiences* □ STT PSY: *New Immigrant* □ Provided additional orientation about:_____
4. Do you plan to stay in this area for the rest of your pregnancy? □ Yes □ No, explain: _____ □ Unsure, explain: _____	Intervention/Referral: □ Discussed the benefits and importance of regular prenatal care for her and the baby □ Provided assistance in transferring her care □ Referred to/date:_____
5. Delivery Hospital: _____ □ Informed/agrees □ Informed/disagrees	Intervention/Referral: □ Educated per protocol □ Explained the risk of not delivering at the affiliated hospital □ Notified provider/date:_____ □ Other _____
6. How many years of school have you completed? □ 0-8 years □ 9-11 years □ 12-16 years □ 16+ years	Intervention/Referral: □ Referred to school program for pregnant/parenting teens/date:_____ □ Referred to adult school/GED Program/date:_____ □ Referred to English as a Second Language (ESL) Program/date:_____ □ Referred to/date:_____
7. What language do you prefer to speak? □ English □ Spanish □ Other: _____ What language do you prefer to read? □ English □ Spanish □ Other: _____	Intervention/Referral: □ Reviewed/discussed STT FS: □ *Cross Cultural Communication* □ *Dealing with Language Barriers* □ *Guidelines for Using Interpreters* □ Provided education in preferred language □ Interpretation services requested from:_____

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

Economic Resources

14. a) Are you currently working or going to school? □ No □ Yes, Type of school/work: _____ Hours per week: _____ b) Do you plan to work or go to school while you are pregnant? □ Yes □ No c) Do you plan to return to work/school after baby is born? □ Yes □ No	Intervention/Referral: □ Referred to school program for pregnant/parenting teens (if under 18 and has not graduated or passed the California High School Proficiency Exam/date: _____ □ Reviewed/discussed STT HE: □ *Workplace Safety* □ ***Keep Safe at Work*** STT PSY: □ *Financial Concerns,* □ *Legal/Advocacy Concerns* □ Reviewed/discussed pumping/storing breastmilk per STT NUTR: *Breastfeeding* □ Referred to childcare/date:_____ □ Referred to/date:_____
15. Will the father/partner/caregiver provide financial support for you and the baby? □ Yes □ No □ Unsure Other sources of financial help:_____	Intervention/Referral: □ Reviewed/discussed STT PSY: *Financial Concerns* for information on the father's requirement to pay child support □ Reviewed/discussed STT PSY: *Legal/Advocacy Concerns* □ Referred to LA County Child Support Services: 1-866- 901-3212/date:_____ □ Referred to/date:_____

Client Name/ID:

16. Are you receiving any of the following?

	0-13 Weeks		14-27 Weeks		28-40 Weeks		Referral & Date
	Yes	No	Yes	No	Yes	No	
WIC*	□	□	□	□	□	□	
CalFresh (Food Stamps)	□	□	□	□	□	□	
CalWORKs	□	□	□	□	□	□	
Medi-Cal	□	□	□	□	□	□	
Emergency Food Assistance	□	□	□	□	□	□	
Pregnancy disability benefits	□	□	□	□	□	□	
Other:_____	□	□	□	□	□	□	

Intervention:
- □ Reviewed/discussed STT First Steps: □ *Making Successful Referrals* and □ *Women, Infants and Children (WIC) Supplemental Nutrition Program*
  STT PSY: □ *Financial Concerns*
- □ Referred to local WIC Program

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

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

b) In the past 12 months, did you experience that the food you bought just didn't last and you didn't have money to get more?
□ No □ Yes, explain: _____

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

Housing

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

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

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

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

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

Intervention/Referral:
- □ Reviewed/discussed STT PSY: *Financial Concerns*_____
- □ Referred to LA County Housing Resource Center: 1-877-428-8844/date:_____
- □ Referred to emergency housing/homeless shelter/date:_____
- □ Referred to LA County Lead Poisoning Prevention Hotline: 1-800-LA-4-LEAD/date:_____
- □ Referred to provider/date: _____
- □ Referred to/date:_____

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

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

Client Name/ID:

23. Do you have the following where you live?	0-13 Wks		14-27 Wks		28-40 Wks	
	Yes	No	Yes	No	Yes	No
Toilet	□	□	□	□	□	□
Stove/place to cook	□	□	□	□	□	□
Tub/shower	□	□	□	□	□	□
Electricity	□	□	□	□	□	□
Refrigerator	□	□	□	□	□	□
Hot/cold water	□	□	□	□	□	□
Phone	□	□	□	□	□	□
Smoke/Carbon Monoxide detectors	□	□	□	□	□	□
Windows that open/close	□	□	□	□	□	□

Intervention/Referral:
□ Reviewed/discussed STT NUTR: □ *Cooking and Food Storage*_____ □ *Food Safety*_____ □ ***When You Cannot Refrigerate: Choose These Foods***__ □ ***Tips for Cooking and Storing Food***_____ □ ***Don't Get Sick From the Foods You Eat***_____
□ Referred to LA County Housing Resource Center 1-877-428-8844/date:_____
□ Referred to HUD 1-213-894-8000/date: _____
□ Referred to Housing Rights Center 1-800-477-5977/date: _____
□ Referred to local fire department/date: _____
□ Referred to social worker/date:_____

24. Do you have a gun in your home?
□ No
□ Yes, how is it stored? _____

Intervention/Referral:
□ Provided information about safe gun storage
□ Educated client that unwanted guns may be turned in to most local law enforcement agencies/date:_____
□ Referred to/date:_____

Transportation

25. Will you have any problems coming to your appointments or attending classes due to transportation, childcare, work, school, or another reason?

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

Intervention/Referral:
□ Referred to childcare/date:_____
□ Referred to transportation services/date:_____
□ Referred to/date:_____
□ Provided bus tokens or taxi vouchers/date: _____

26. a) When you ride in a car, do you use seatbelts?
□ Always
□ Sometimes
□ Never

b) Do you know how to use a seat belt when pregnant?
□ Yes
□ No

Intervention/Referral:
□ Reviewed/discussed STT HE Handout: ***Pregnant? Steps for a Healthy Baby***

27. Do you have a car seat for the new baby?
14-27 Weeks: □ Yes □ No
28-40 Weeks: □ Yes □ No

Intervention/Referral:
□ Reviewed/discussed to STT HE: □ *Infant Safety and Health*_____ □ ***Keep Your Baby Safe and Healthy*** _____
□ Give referral to free or low-cost car seat program/date:_____
□ Delivery hospital provides car seat prior to discharge:

28. How will you get to the hospital?

14-27 Weeks: _____
□ Unsure □ No transportation available

28-40 Weeks: _____
□ Unsure □ No transportation available

Intervention/Referral:
□ Reviewed/discussed STT HE: □ *Preterm Labor*_____ □ *Hospital Orientation* _____ □ ***If Your Labor Starts Too Early***_____
□ Assist client in scheduling tour of delivery hospital/date:_____
□ Provided bus tokens or taxi vouchers/date:_____
□ Referred to childcare/date:_____
□ Referred to transportation services/date:

Current Health Practices

29. Do you have a primary care doctor for you and your family?
□ Yes □ No

Intervention/Referral:
□ Reviewed/discussed STT Appendix: *Introduction to Managed Care*
□ Referred to/date:_____

30. Do you have a doctor for your baby?
14-27 Weeks: □ No □ Yes, who?_____
28-40 Weeks: □ No □ Yes, who?_____

Intervention/Referral:
□ Reviewed/discussed STT HE: □ *Infant Safety and Health*_____ □ ***When Your Newborn Baby is Ill***_____ □ ***Your Baby Needs to be Immunized***_____
□ Referred to CHDP provider/date:_____

31. a) Have you been to a dentist in the last 6 months?
□ Yes □ No

b) Do you have any problems with your teeth, gums, or mouth such as toothaches, bleeding gums, or a bad taste or smell?
0-13 Weeks: □ No □ Yes:_____
14-27 Weeks: □ No □ Yes:_____
28-40 Weeks: □ No □ Yes:_____

Intervention/Referral:
□ Reviewed/discussed STT HE □ *Oral Health During Pregnancy*_____ □ ***Prevent Gum Problems When You Are Pregnant***_____ □ ***See a Dentist When You Are Pregnant***_____ □ ***Keep Your Teeth and Mouth Healthy! Protect Your Baby Too***_____
□ Referred to registered dietitian/date:_____
□ Referred to dentist/date:_____

Client Name/ID:

32. How many total hours do you sleep at night?

		How many total min/hours do you nap during the day?	
0-13 Weeks:		0-13 Weeks:	
14-27 Weeks:		14-27 Weeks:	
28-40 Weeks:		28-40 Weeks:	

Intervention/Referral:
- □ Discuss using extra pillows for joint or back discomfort. To improve relaxation, offer deep breathing, visualization and relaxation techniques/date: _____
- □ Reviewed/discussed STT PSY: □ *Emotional or Mental Health Concerns*_____ □ *Depression*_____ □ ***How Bad are Your Blues?*** _____
- □ Referred to social worker/date:_____
- □ Referred to/date:_____

33. Do you exercise?

0-13 Weeks: □ No
□ Yes, type/frequency:_____

14-27 Weeks: □ No
□ Yes, type/frequency:_____

28-40 Weeks: □ No
□ Yes, type/frequency:_____

Intervention/Referral:
- □ Reviewed/discussed STT HE: □ *Safe Exercise and Lifting*_____ □ ***Exercises To Do When You Are Pregnant***_____ □ ***Stay Active When You Are Pregnant*** _____ □ ***Keep Safe When You Exercise***_____
- □ Referred to provider for discussion of vigorous exercise (lifting heavy weights, running, etc.) during pregnancy/date:_____
- □ Referred to exercise or fitness resources that are low-cost/date:_____

34. Are you currently smoking or using any tobacco products (including hookah or vaping)?

0-13 Weeks:	□ No	□ Yes: How much per day?_____ For how many years?_____ Have you tried to quit? □ Yes □ No
14-27 Weeks:	□ No	□ Yes, how much per day?_____ Have you tried to quit? □ Yes □ No
28-40 Weeks:	□ No	□ Yes, how much per day?_____ Have you tried to quit? □ Yes □ No

35. Are you often around other people who smoke cigarettes or any other tobacco products?
□ Yes □ No

Intervention/Referral:
- □ Reviewed/discussed STT HE: □ *Tobacco Use*_____ □ ***You Can Quit Smoking***_____ □ *Secondhand Tobacco Smoke*_____
- □ Referred to California Smokers' Helpline for free counseling or information about secondhand smoke: 1-800-NO-BUTTS or 1-800-45-NO-FUME (Spanish)/date:_____
- □ Referred to smoking cessation program/date:_____
- □ Referred to provider for additional counseling on smoking cessation/date: _____

36. Do you use or have exposure to any of the following at home, work, or doing any hobbies?

	0-13 Weeks	14-27 Weeks	28-40 Weeks
Products like bleach, ammonia or oven cleaners	□	□	□
Pesticides or chemicals	□	□	□
Cooking with clay pottery	□	□	□
Jewelry making	□	□	□
Glue	□	□	□
Fertilizers	□	□	□
Cat litter box	□	□	□
Pet turtles or reptiles	□	□	□
Rodents	□	□	□
Douching	□	□	□
Hot baths or saunas	□	□	□
X-Rays	□	□	□
Other:_____	□	□	□
None	□	□	□

Intervention/Referral:
- □ Reviewed/discussed STT HE: □ *Cautions While Pregnant*_____ □ *Workplace Safety*_____ □ ***Pregnant? Steps for a Healthy Baby***_____ □ ***Keep Safe at Work***_____
- □ Referred to provider to discuss any harmful exposure to chemicals at home or work/date:_____
- □ Referred to MotherToBaby: www.mothertobaby.org or 1-866-626-6847/date: _____

37. At home, where do you store the following?:
Vitamins _____
Medications _____
Cleaning Supplies _____

Are these things kept out of the reach of children?
□ Yes □ No

Intervention/Referral:
- □ Reviewed/discussed STT HE Handout: ***Keep Your New Baby Safe and Healthy***

Client Name/ID:

38. Have either of your parents had a drug or alcohol problem? □No □Yes, describe:_____ Does your partner have a problem with drugs or alcohol? □No □Yes, describe:_____ Have you had a problem with drugs or alcohol in the past? □No □Yes, describe:_____	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Drug and Alcohol Use*_____ □ ***You Can Quit Using Drugs or Alcohol***_____ STT PSY: □ *Perinatal Substance Use/Abuse*_____ □ *Neonatal Abstinence Syndrome* _____ ***Your Baby Can't Say "No"***_____ □ ***Drugs and Alcohol, When You Want to STOP Using***_____ □ Notified provider of client's drug/alcohol use/date:_____ □ Referred to Alcoholics Anonymous (AA)/date: _____ □ Referred to Narcotics Anonymous (NA)/date: _____ □ Referred client to Medi-Cal drug treatment facility/date:_____ □ Referred to social worker/date:_____ □ Referred to Adult Children of Alcoholics, Al-Anon, or Alateen/ date:_____ _____ □ Referred to/date: _____
39. Have you used drugs or alcohol during this pregnancy? Drugs would include things like marijuana, heroin, cocaine, or ecstasy and alcohol would include things like beer, wine, or liquor. 0-13 Weeks: □ No □ Yes, describe:_____ 14-27 Weeks: □ No □ Yes, describe:_____ 28-40 Weeks: □ No □ Yes, describe:_____ If you use drugs and/or alcohol, are you interested in quitting? 0-13 Weeks: □ N/A □ Yes □ No 14-27 Weeks: □ N/A □ Yes □ No 28-40 Weeks: □ N/A □ Yes □ No	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Drug and Alcohol Use*_____ □ ***You Can Quit Using Drugs or Alcohol***_____ STT PSY: □ *Perinatal Substance Use/Abuse*_____ □ *Neonatal Abstinence Syndrome* _____ ***Your Baby Can't Say "No"***_____ □ ***Drugs and Alcohol, When You Want to STOP Using***_____ □ Notified provider of client's drug/alcohol use/date:_____ □ Referred to Alcoholics Anonymous (AA)/date: _____ □ Referred to Narcotics Anonymous (NA)/date: _____ □ Referred client to Medi-Cal drug treatment facility/date:_____ □ Referred to social worker/date:_____ □ Referred to Adult Children of Alcoholics, Al-Anon, or Alateen/ date:_____ _____ □ Referred to/date: _____
40. Are you taking a prenatal vitamin every day? 0-13 Weeks: □ Yes □ No: 14-27 Weeks: □ Yes □ No 28-40 Weeks: □ Yes □ No	Intervention/Referral: □ Prenatal vitamins prescribed by provider/date: _____ □ Encouraged client to continue taking prenatal vitamins (and any other supplements recommended by provider)/date: _____
41. Are you taking any prescription, over-the-counter, or herbal medications? Examples: iron, pain medication, antidepressants, antacids, allergy medication, laxatives, or herbal remedies like yerba buena, ginseng, or manzanilla? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	□ Notified provider of any medication/supplement use to ensure safety during pregnancy/date:_____ □ Reviewed/discussed STT NUTR: □ *Prenatal Supplements: Vitamins, Minerals, and Other Supplements*_____ □ ***Take Prenatal Vitamins and Minerals***_____□ ***If You Need Iron Pills***_____ □ ***You May Need Extra Calcium*** _____ □ Referred to MotherToBaby: www.mothertobaby.org or 1-866-626-6847/date: _____ □ Referred to/date:_____

Pregnancy Care

42. Besides having a healthy baby, what are your goals for this pregnancy? _____	Intervention/Referral: □ Referred to/for:_____
43. Do you plan to have someone with you: During labor? 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____ When you first come home with the baby? 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Refer to childbirth classes/date:_____ □ Refer to home visitation program/date:_____ □ Refer to Medi-Cal doula services: _____ □ Referred to/date: _____
44. If you had a baby before, where was it delivered? □ N/A □ Clinic □ Hospital □ Home □ Other:_____ Did you or the baby have any problems? □ No □ Yes, explain:_____	Intervention/Referral: □ Notified provider of prior complications:_____ □ Provided information about the delivery hospital, including tours, registration, parking, and how to get there from her home

Client Name/ID:

45. Have you ever lost any children? (miscarriage, stillbirth, SIDS, immigration, custody, etc.)
- □ No
- □ Yes, please explain:_____

Intervention/Referral:
- □ Reviewed/discussed STT PSY: □ *Perinatal Loss* □ ***Loss of Your Baby*** □ ***Ways to Remember Your Baby***
- □ Referred to grief and loss resource: _____
- □ Referred to First Candle grief support line at: 1-800-221-7437
- □ Discussed Return to Zero materials (available at www.rtzhope.org)
- □ Referred to social worker or mental health/date: _____
- □ Referred to/date:_____

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

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

Intervention/Referral:
- □ Reviewed/discussed STT Appendix: *Prenatal Laboratory and Diagnostic Tests*_____
- □ Answered questions/concerns:_____
- □ Referred to provider for/date:_____

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

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

Intervention/Referral:

Edema:
- □ Notified provider of sudden weight gain or swelling of the face/date: _____
- □ Notified provider of higher than normal blood pressure/date:_____
- □ Encouraged client to elevate her feet, avoid eating salty foods, and drink at least 8 glasses of water a day.

Diarrhea:
- □ Notified provider of diarrhea symptoms/date: _____
- □ Referred to/for:_____
- □ Reviewed/discussed STT NUTR: □ *Lactose Intolerance*_____ □ ***Do You Have Trouble with Milk Foods?***_____ □ ***Foods Rich in Calcium***____

Constipation:
- □ Reviewed/discussed STT NUTR: □ *Constipation*_____ □ ***Constipation: What You Can Do***_____ □ ***Constipation: What Products You Can and Cannot Use***_____
- □ Notified provider of constipation symptoms/date:_____

Nausea/Vomiting:
- □ Notified provider of nausea/vomiting symptoms/date: _____
- □ Reviewed/discussed STT NUTR: □ *Nausea & Vomiting*_____ □ ***Nausea: Tips that Help***_____ □ ***Nausea: What To Do When You Vomit***_____ □ ***Nausea: Choose These Foods***_____

Leg cramps & Hemorrhoids:
- □ Education on _____was provided/date: _____
- □ Notified provider of _____ symptoms/date:_____

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

Varicose veins & Headaches:
- □ Education on _____was provided/date: _____
- □ Notified provider of _____ symptoms/date:_____

Backaches, Vaginal Bleeding, & Abdominal cramping/contractions:
- □ Reviewed/discussed STT HE: □ *Preterm Labor*_____ □ ***If Your Labor Starts Too Early***_____ □ *Safe Exercise & Lifting*_____ □ ***Exercises To Do When You Are Pregnant***_____
- □ Notified provider of _____symptoms/date:_____
- □ Additional education (describe in progress note if more space needed):_____
_____

Client Name/ID:

48. Does the doctor say there are any problems with this pregnancy? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Referred to the provider or health educator for:_____ □ Referred to a registered dietitian/date:_____ □ Reviewed/discussed as needed: STT HE: □ *Preterm Labor*_____ □ ***If Your Labor Starts Too Early***_____ □ *Kick Counts*_____ □ ***Count Your Baby's Kicks***_____ □ *Labor Induction*_____ □ ***What You Need to Know About Labor Induction***_____ □ *Multiple Births - Twins and More*_____ □ ***Getting Ready for Multiples***_____ □ Referred to a Prenatal Diagnostic Center (PDC)/date: _____ □ Referred to/date:_____
49. Compared to your previous pregnancies, is there anything you would like to change about the care you receive this time? □ N/A □ No □ Yes, explain:_____	Intervention/Referral: □ Notified provider of the client's requests or concerns □ Referred to/date:_____
50. Who has given you the most advice about your pregnancy? □ Mother □ Grandmother □ Partner □ Mother-in-law □ Friend □ Doula □ No one □ Other:_____ 51. What are the most important things they have told you? Describe:_____	Intervention/Referral: □ Notified provider regarding any harmful advice □ Encouraged client to have support person participate in prenatal education/classes □ Referred to/date: _____
52. Do you have any traditions, customs or religious beliefs about pregnancy? □ No □ Yes: Please explain:_____ _____ If yes, Conflicts with medical recommendations? □ No □ Yes	Intervention/Referral: □ Reviewed/discussed STT First Steps: □ *Cultural Considerations* □ *Cross-Cultural Communication* □ *Clients with Alternative Health Care Experiences* □ Referred to provider for:_____
53. Would you like to become pregnant in the next 18 months? 14-27 Weeks: □ Yes □ No 28-40 Weeks: □ Yes □ No	Intervention/Referral: □ Discussed the importance of spacing 18 months between pregnancies/date: ____ _____ □ Reviewed/discussed STT HE: *Family Planning Choices*_____ □ Referred to provider to discuss the effectiveness of her preferred birth control method, pregnancy spacing, and effects of contraceptives on breastfeeding/date: _____ □ Encouraged client to talk to an OB or family planning provider about birth control methods that are less detectable (such as a shot, implant, or an IUD with the strings trimmed). □ Provided informed consent on sterilization and 30 day waiting period (if client's choice)/date:_____ □ Referred to/date:_____
54. Has your partner ever pressured you to become pregnant, interfered with your birth control, or refused to wear a condom? □ Never □ Sometimes □ Often	
55. Do you plan to use birth control after this pregnancy? 14-27 Weeks: □ No □ Undecided □ If yes, what method(s): Most effective methods (when used correctly) □ IUD □ Vasectomy □ Patch □ Implant □ Injection/shot □ Ring □ Tubal ligation □ Pills Less effective methods (higher failure rate) □ Condoms □ Diaphragm □ Abstinence □ Spermicides □ Cervical cap □ Withdrawal □ Fertility awareness methods □ Other:_____ 28-40 Weeks: □ No □ Undecided □ If yes, what method(s): Most effective methods (when used correctly) □ IUD □ Vasectomy □ Patch □ Implant □ Injection/shot □ Ring □ Tubal ligation □ Pills Less effective methods (higher failure rate) □ Condoms □ Diaphragm □ Abstinence □ Spermicides □ Cervical cap □ Withdrawal □ Fertility awareness methods □ Other:_____	

Client Name/ID:

56. These questions help us identify any risk factors for diseases like chlamydia, gonorrhea, genital herpes, hepatitis B & C, syphilis, or HIV:			
Have you or your partner recently had sex with anybody else?	□ Yes	□ Unsure	□ No
Have you or any partners ever had an STD?	□ Yes	□ Unsure	□ No
Have you ever had sex while using alcohol or drugs?	□ Yes	□ Unsure	□ No
Have you or any partners exchanged sex for drugs, money, or shelter?	□ Yes	□ Unsure	□ No
Have you or any partners ever shared needles?	□ Yes	□ Unsure	□ No
57. Any change in HIV/STI risk status? 14-27 Weeks: □ Yes □ No 28-40 Weeks: □ Yes □ No			

Intervention/Referral:
- □ Notified the provider of risky sexual behaviors or symptoms of STIs/date:_____
- □ Reviewed/discussed STT HE: □ *STIs (Sexually Transmitted Infections)*_____ □ *HIV and Pregnancy*_____ □ ***What You Should Know About STDs***_____ □ ***What You Should Know About HIV***_____ □ ***You Can Protect Yourself and Your Baby from STDs***_____
- □ Referred to Los Angeles County STD Program Hotline for more information and referrals to STD clinics and HIV test sites in Los Angeles County: English/Spanish: 1-800-758-0880/date:_____
- □ Referred to confidential/anonymous STD testing location/date: _____ _____

Educational Interests

58. How do you like to learn new things?
- □ Text messages/apps □ One-on-one education
- □ Reading/handouts □ Videos
- □ Group classes □ Other:_____

Intervention/Referral:
- □ Signed up for Text4Baby by texting BABY or (BEBE for Spanish) to 511411
- □ Provided education in client's preferred learning methods

59. Will someone be able to attend prenatal classes with you?
- □ No
- □ Unsure
- □ Yes, who? _____

Intervention/Referral:
- □ Encouraged the client to share prenatal education materials with a support person like the partner/father of the baby, friend, parent, or close relative

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

Intervention/Referral:
- □ Contact the client's health plan or visit Medi-Cal's website for more information about hearing and/or vision services and eligibility
- □ Referred to/date:_____

61. Do you have experience with pregnancy, prenatal care, labor & delivery, postpartum self-care, and infant care and safety?
□ Yes □ No

Intervention/referral:
- □ Enrolled in Text4Baby by texting BABY or (BEBE for Spanish) to 511411
- □ Reviewed/discussed STT HE Handouts: □ ***Pregnant? Steps for a Healthy Baby*** □ ***Keep Your New Baby Safe and Healthy***
- □ Referred to home visitation program/date: _____
- □ Referred to Medi-Cal doula services/date: _____
- □ Referred to group education classes/date: _____

62. Would you like information about the following topics?	0-13 Weeks		14-27 Weeks		28-40 Weeks	Date Education Provided	Teaching Method(s)
How your baby grows (fetal development)	□		□		□		
How your body changes during pregnancy	□		□		□		
Habits for a healthy pregnancy/baby	□		□		□		
What happens during labor/delivery	□		□		□		
Preparing for the delivery hospital	□		□		□		
Helping your child(ren) get ready for a new baby	□		□		□		
How to take care of yourself after the baby comes	□		□		□		
Chest/Breastfeeding	□		□		□		
How to take care of your baby (infant health & safety)	□		□		□		
Infant development	□		□		□		
Circumcision	□		□		□		
Immunizations needed during pregnancy (flu and Tdap)	□		□		□		
Birth control methods	□		□		□		
Other	□		□		□		

Client Name/ID:

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

Nutrition: Anthropometric

64. Weight gain in last pregnancy: _____ lbs. □ Unknown □ N/A 65. Pre-pregnant weight: _____ lbs. Height: _____ Recommended weight gain goal for this pregnancy: Single Pregnancy □ Underweight: 28-40 lbs □ Normal weight: 25-35 lbs □ Overweight: 15-25 lbs □ Obese: 11-20 lbs Twin Pregnancy □ Normal: 37-54 lbs □ Overweight: 31-50 lbs □ Obese: 25-42 lbs	Intervention/Referral: □ Refer to STT NUTR: *Weight Gain During Pregnancy*- Section: "*How to Determine Gestational Weight Gain Goals and Assess Weight Gain"* □ Review/discussed Handout: ***MyPlate for Pregnant and New Parents including Breastfeeding*** and ***Tips to Gain Weight*** Underweight: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* – Section: "*Underweight"* □ Review/discussed Handout: ***MyPlate for Pregnant and New Parents including Breastfeeding*** and ***Tips to Gain Weight*** □ Recommended regular meals and larger portions □ Discussed weight gain goal per month = 3-4 lbs for single pregnancy Overweight: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* – Section: "*Overweight"* □ Reviewed/discussed STT Nutrition handout: ***MyPlate for Pregnant and New Parents including Breastfeeding*** □ Recommended smaller portions, more fruits and vegetables, and low/nonfat foods □ Discussed weight gain goal per month = 2-3 lbs after 16th week for single pregnancy Obese: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* – Section: " *Obese"* □ Review and discuss STT Nutrition handout: ***MyPlate for Pregnant and New Parents including Breastfeeding*** □ Recommended smaller portions, more fruits and vegetables, and low/nonfat foods □ Discussed weight gain goal per month = 2.5 lbs after 16th week for single pregnancy

Client Name/ID:

66. Net Weight Gain

0-13 Weeks: _____lbs.

□ Adequate □ Inadequate
□ Excessive □ Weight Loss

14-27 Weeks: _____lbs.

□ Adequate □ Inadequate
□ Excessive □ Weight Loss

28-40 Weeks: _____lbs.

□ Adequate □ Inadequate
□ Excessive □ Weight Loss

Table 2: RECOMMENDATIONS FOR TOTAL AND RATE OF WEIGHT GAIN DURING PREGNANCY BASED ON PRE-PREGNANCY BMI[1]

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

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

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

Example

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

Intervention/Referral

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

Excessive Weight Gain:

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

Inadequate Weight Gain:

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

Weight Loss:

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

Nutrition: Biochemical

Client Name/ID:

67. Consult with provider if there are abnormal lab values and discuss treatment prescribed. 0-13 Weeks: Date blood drawn: _____ Hgb: _____ (<11g/L) Hct: _____ (<33%) Glucose: _____ MCV: _____ 14-27 Weeks: Date blood drawn: _____ Hgb: _____ (<10.5g/L) Hct: _____ (<32%) Glucose: _____ MCV: _____ 28-40 Weeks: Date blood drawn: _____ Hgb: _____ (<11g/L) Hct: _____ (<33%) Glucose: _____ MCV: _____ **OGTT** Initial Prenatal Visit *(if applicable)* Date:_____ Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 Hr: _____ □ N/A 24-28 weeks Date :_____ Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 Hr: _____	Intervention/Referral: □ Consult with provider on abnormal lab values and education interventions/date:_____ □ Anemia, iron prescribed/date: _____ □ Referred to/date: _____

Nutrition: Clinical

68. Current serious infections? (Ex: Kidney infection, HIV, TB, etc.) 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Referred to registered dietitian/date:_____ □ Referred to provider/date:_____ □ Referred to/date: _____
69 Anemia 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR: *Iron Deficiency and Other Anemias*_____ □ For Iron Deficiency Anemia, reviewed/discussed STT NUTR: □ ***Get the Iron You Need***_____ □ ***Iron Tips***_____ □ ***Iron Tips – Take Two!***_____ □ ***My Action Plan for Iron***_____ □ For Folic Acid Deficiency Anemia, reviewed/discussed: STT NUTR: □ ***Get the Folic Acid You Need***_____ □ ***Folic Acid: Every Woman, Every Day***_____ □ For Vitamin B_{12} Deficiency Anemia: reviewed/discussed STT NUTR: □ Vegetarian Eating_____ □ ***When You Are Vegetarian: What You Need to Know***_____ □ ***Vitamin B_{12} is Important***_____ □ Referred to registered dietitian/date:_____ □ Referred to provider/date:_____
70. Diabetes Pre-pregnancy: □ No □ Yes Past pregnancy: □ No □ Yes Current pregnancy: 0-13 Weeks: □ No □ Yes 14-27 Weeks: □ No □ Yes 28-40 Weeks: □ No □ Yes	Intervention/Referral: □ Discussed importance of keeping all prenatal appointments and labs, as well as maintaining a healthy diet and moderate exercise/date:_____ □ Reviewed/discussed STT GDM: □ *Gestational Diabetes Mellitus (GDM)* □ ***MyPlate for People with Gestational Diabetes***_____ □ ***If You Have Diabetes While You Are Pregnant: Questions You May Have***_____ □ ***If You Have Diabetes While You Are Pregnant: Ways to Lower Your Stress***_____ □ Referred to diabetes specialist/date:_____ □ Referred to registered dietitian/date: _____

Client Name/ID:

71. Hypertension Pre-pregnancy: □ No □ Yes Past pregnancy: □ No □ Yes Current pregnancy: 0-13 Weeks: □ No □ Yes 14-27 Weeks: □ No □ Yes 28-40 Weeks: □ No □ Yes 72. History of poor pregnancy outcome (low birth weight, preterm labor/delivery, large for gest. Age, preeclampsia) □ No □ Yes: _____ 73. Any risk factors indicating the use of Aspirin? (have the patient complete the *Should I do Aspirin?* pocket card) **Notify provider of any "Yes" answers** □ No □ Yes: _____ 74. Other medical/OB problems? (Ex: thyroid, cancer, lupus, etc.) 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Discussed importance of keeping all health care provider appointments/date: _____ □ Reviewed/Discussed STT HE: ***Signs and Symptoms of Heart Disease During Pregnancy and Postpartum*** □ Referred to MotherToBaby for information on medications and maternal medical conditions. The client or provider can call 1-866-626-6847 or visit www.mothertobaby.org /date:_____ □ Discussed whether exercise is safe or not. □ Referred to registered dietitian/date:_____ □ Referred to provider/date:_____
75. Pregnancy interval < 18 months? □ Yes □ No 76. High parity? (≥ 4 births) □ Yes □ No	Intervention/Referral: □ Discussed the importance of a healthy diet to get the nutrients and calories she needs □ Discussed the importance of taking prenatal vitamins every day □ Discussed increased risk of low birth weight, preterm delivery and the pregnancy interval recommended by her healthcare provider
77. Multiple gestation? □ Yes □ No	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Multiple Births—Twins and More*, □ ***Getting Ready for Multiples*** □ ***If Your Labor Starts Too Early*** □ Referred to registered dietitian/date:_____
78. Are you currently chest/breastfeeding? □ Yes □ No	Intervention/Referral: □ Referred to provider (especially if history of miscarriage or preterm labor and she is currently chest/breastfeeding while pregnant) □ Reviewed/discussed STT NUTR: ***MyPlate for Pregnant and New Parents including Breastfeeding*** and the importance of adequate food intake and meeting weight gain goals each month □ Referred to registered dietitian/date:_____

Nutrition: Dietary

79. Have your eating habits changed since you've been pregnant? 0-13 Weeks: □ No □ Yes:_____ 14-27 Weeks: □ No □ Yes:_____ 28-40 Weeks: □ No □ Yes:_____	Intervention/Referral: □ Reviewed client's pregnancy weight, BMI, and weight gain goal for each month. Check to see if they are meeting the weight gain goal according to their BMI □ Reviewed/discussed handout: ***MyPlate for Pregnant and New Parents including Breastfeeding __*** □ Reviewed/discussed lacking food groups and proper proportions on a 10-inch healthy plate if client ate less or gained insufficient weight. □ Reviewed/discussed nutritious food groups and proper proportions on a 10-inch healthy plate if client gained excess weight or ate too much of core nutrients. □ Referred to/date:_____
80. Do you ever crave/eat any of the following: □ Yes: Ice, freezer frost, corn starch, dirt, paint chips, plaster, clay, pottery, paste, other:_____ □ No	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Pica* □ ***MyPlate for Pregnant and New Parents including Breastfeeding*** □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____

Client Name/ID:

81. a) Number of meals/day:_____ b) Meals often skipped? □ Yes □ No c) Number of snacks/day:_____	Intervention/Referral: □ Reviewed/discussed handout: ***MyPlate for Pregnant and New Parents including Breastfeeding*** and discussed the importance of eating foods from all of the different food groups, and the need to eat meals and snacks at regular times throughout the day □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____
82. Who does the following in your home? a) Buys food:_____ b) Cooks/prepares food:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Getting Healthy Foods*, □ ***Tips for Healthy Food Shopping*** □ ***You Can Buy Healthy Food on a Budget*** □ ***You Can Stretch Your Dollars: Choose These Easy Meals*** □ Reviewed/discussed STT NUTR: □ *Cooking & Food Storage* □ *Food Safety* □ ***Tips for Cooking and Storing Food*** □ ***Don't Get Sick From the Foods You Eat*** □ ***Eat Fish Safely – Tips*** □ ***Checklist for Food Safety*** □ ***Lower Your Chances of Eating Food with Unsafe Chemicals in Them*** □ ***Tips for Keeping Foods Safe***
83. Are you on any special diet (medical diet, personal diet, etc.)? 0-13 Weeks: □ Yes, explain:_____ □ No 14-27 Weeks: □ Yes, explain:_____ □ No 28-40 Weeks: □ Yes, explain:_____ □ No	Intervention/Referral: □ Reviewed/discussed STT NUTR: *Weight Gain During Pregnancy* and discussed her specific weight gain goals_____ □ Reviewed/discussed handout: ***MyPlate for Pregnant and New Parents including Breastfeeding _____*** ***(****emphasize proportions of food groups on a 10-inch plate recommended for pregnancy*) □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____
84. Any food allergies? □ No □ Yes:_____ Any foods/beverages you avoid? □ No □ Yes:_____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Lactose Intolerance* □ ***Do You Have Trouble with Milk Foods?*** □ ***Foods Rich in Calcium*** □ Referred to provider/date:_____ □ Referred to registered dietitian/date:_____
85. Are you vegetarian or vegan? □ No □ Yes: Do you eat: □ Milk Products □ Eggs □ Nuts □ Beans □ Chicken/Fish	Intervention/Referral: □ Notified provider client is Vegan/date:_____ □ Reviewed/discussed STT NUTR: □ *Vegetarian Eating* □ ***When You Are a Vegetarian: What You Need to Know*** □ ***Vitamin B12 is Important*** □ Referred to/date:_____
86. 0-13 Weeks: a) How do you plan to feed your baby? □ Chest/Breastfeed □ Formula □ Chest/Breastfeed + Formula □ Undecided b) Have you ever chest/breastfed or tried to chest/breastfeed? □ If yes, for how long? _____ □ No □ N/A c) Did you chest/breastfeed for as long as you wanted? □ Yes □ No, explain:_____ □ N/A	Intervention/Referral: □ Discussed benefits of breastfeeding and risks of formula feeding and supplementation/date: _____ □ Reviewed/discussed STT NUTR: □ *Breastfeeding* _____ □ *Tips for Addressing Breastfeeding Concerns*_____ □ ***My Birth Plan***_____ □ WIC Handout: □ ***How Does Formula Compare to Breastmilk?***_____ □ Referred to WIC/date:_____ □ Referred to breastfeeding education classes/date:_____ □ Referred to/date:_____

Client Name/ID:

14-27 Weeks: a) What do you think about breastfeeding your new baby? □ Not interested □ Thinking about it □ Wants to □ Definitely will □ Other: _____ b) What questions do you have about feeding your baby? _____	Intervention/Referral: □ Answered chest/breastfeeding questions/concerns □ Reviewed/discussed STT NUTR: □ *Breastfeeding* □ *Tips for Addressing Breastfeeding Concerns* □ ***My Birth Plan*** □ ***My Action Plan for Breastfeeding*** □ Referred to WIC/date:_____ □ Referred to chest/breastfeeding education classes:_____ □ Referred to/date:_____
28-40 Weeks: a) How do you plan to feed your baby during the first month? □ Chest/Breastfeed □ Formula □ Chest/Breastfeed + Formula b) If you are going to chest/breastfeed, who can you go to for chest/breastfeeding help? _____ c) What questions do you have about feeding your baby? _____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Breastfeeding* □ *Tips for Addressing Breastfeeding Concerns* □ *What to Expect While Breastfeeding: Birth to Six Weeks* □ ***My Action Plan for Breastfeeding*** □ ***My Birth Plan*** □ ***Nutrition and Breastfeeding: Common Questions and Answers*** □ Provided education on safe formula preparation and feeding □ Discussed how supplementing with formula can decrease milk production □ Referred to WIC/date:_____ □ Referred to breastfeeding education classes/date:_____ □ Referred to/date:_____

87. Diet intake assessment completed:

0-13 Weeks: □ Perinatal Food Group Recall (PFGR) □ Perinatal Food Group Recall *for Gestational Diabetes* (PFGR) □ 24-hour Perinatal Dietary Recall □ Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: ☐ Yes ☐ No	Intervention/Referral: □ Reviewed/discussed Handout: □ ***MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding*** □ Reviewed/discussed Handout: □***MyPlate for People with Gestational Diabetes/MyPlan for People with Gestational Diabetes*** □ Referred to CalFresh _____ □ Referred to WIC _____ □ Referred to food bank _____ □ Referred to registered dietitian/date: _____ □ Notified provider/date: _____
14-27 Weeks: □ Perinatal Food Group Recall (PFGR) □ Perinatal Food Group Recall *for Gestational Diabetes* (PFGR) □ 24-hour Perinatal Dietary Recall □ Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: ☐ Yes ☐ No	Intervention/Referral: □ Reviewed/discussed Handout: □ ***MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding*** □ Reviewed/discussed Handout: □***MyPlate for People with Gestational Diabetes/MyPlan for People with Gestational Diabetes*** □ Referred to CalFresh _____ □ Referred to WIC _____ □ Referred to food bank _____ □ Referred to registered dietitian/date:_____ □ Notified provider/date:_____
28-40 Weeks: □ Perinatal Food Group Recall (PFGR) □ Perinatal Food Group Recall *for Gestational Diabetes* (PFGR) □ 24-hour Perinatal Dietary Recall □ Perinatal Food Frequency Questionnaire (PFFQ) Diet adequate as assessed?: ☐ Yes ☐ No	Intervention/Referral - □ Reviewed/discussed Handout: □ ***MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding*** □ Reviewed/discussed Handout: □***MyPlate for People with Gestational Diabetes/MyPlan for People with Gestational Diabetes*** □ Referred to CalFresh _____ □ Referred to WIC _____ □ Referred to food bank _____ □ Referred to registered dietitian/date:_____ □ Notified provider to/date:_____

Client Name/ID:

Coping Skills

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

	0-13 Weeks	14-27 Weeks	28-40 Weeks
Divorce/separation	□	□	□
Recent death	□	□	□
Illness (cancer, abnormal Pap smear, etc.)	□	□	□
Unemployment	□	□	□
Immigration	□	□	□
Legal	□	□	□
Probation/parole	□	□	□
Child Protective Services/DCFS	□	□	□
Other:_____	□	□	□
None	□	□	□

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

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

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

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

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

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

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

94. Perinatal Depression Screening (use PHQ-9)

0-13 Weeks:

Patient Health Questionnaire -9 (PHQ-9)

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

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

Client Name/ID:

14-27 Weeks: Patient Health Questionnaire -9 (PHQ-9) Total Score: □ 0-4 (None/Minimal) □ 5-9 (Mild) □ 10-14 (Moderate) □ 15-19 (Moderate Severe) □ 20-27 (Severe)	Intervention/Referral: □ Notified provider of score of 5+ higher (PHQ-9) □ Reviewed/discussed STT PSY: □ *Emotional/Mental Health Concerns* □ *Depression*__□ ***How Bad Are Your Blues***?_____ □ Provided handout: _____ □ Encouraged client to inform provider if symptoms worsen □ Referred to Postpartum Support International at: 1-800-944-4773 □ Referred to social worker or mental health clinic: Date:_____ □ Referred to DMH ACCESS hotline 1-800-854-7771: Date: _____ □ Referred to Maternal Mental Health Hotline at: 1-833-TLC-MAMA (call/text)
28-40 Weeks: Patient Health Questionnaire -9 (PHQ-9) Total Score: □ 0-4 (None/Minimal) □ 5-9 (Mild) □ 10-14 (Moderate) □ 15-19 (Moderate Severe) □ 20-27 (Severe)	Intervention/Referral: □ Notified provider of score of 5+ higher (PHQ-9) □ Reviewed/discussed STT PSY: □ *Emotional/Mental Health Concerns* □ *Depression*__□ ***How Bad Are Your Blues***?_____ □ Provided handout: _____ □ Encouraged client to inform provider if symptoms worsen □ Referred to Postpartum Support International at: 1-800-944-4773 □ Referred to social worker or mental health clinic: Date:_____ □ Referred to DMH ACCESS hotline 1-800-854-7771: Date: _____ □ Referred to Maternal Mental Health Hotline at: 1-833-TLC-MAMA (call/text)
95. Are you currently receiving services from a local agency such as case management, home visiting, counseling, etc.? □ No □ Yes, please explain:_____	Intervention/referral: □ Obtained client's signed consent to contact agency and coordinate services using an authorization to release information form □ Agency information:_____ □ Client declined case coordination
96. Have you ever attended individual or group counseling or therapy? □ No □ If Yes, when and why? _____ Have you ever been prescribed medications for emotional problems (sadness, anger, nervousness, irritability, difficulty sleeping, etc.)? □ No □ If Yes, when and why? _____ Have you ever been hospitalized for emotional problems, or thinking about hurting yourself, etc.? □ No □ If Yes, when and why? _____	Intervention/referral: □ Reviewed/discussed STT PSY: □ *Emotional or Mental Health Concerns* □ *Depression.* □ Notified provider of history:_____ □ Referred to home visitation program/date: _____ □ Referred to social worker /date:_____ □ Referred to mental health clinic/date: _____ □ Referred to/date: _____

97. Have you ever been emotionally or physically abused by your partner or someone important to you? □ No □ Yes, please explain:_____ 98. Do you ever feel afraid of your partner? □ No □ Yes, please explain:_____ 99. Within the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone? □ No □ Yes, by whom? _____ How many times? _____	Intervention/referral: □ Informed client of mandatory reporting requirement if (1) she has current physical injuries from abuse, or (2) she is under the age of 18/date:_____ □ Notified provider immediately:_____ □ Danger Assessment form completed by provider/date:_____ □ Contacted local law enforcement agency/date:_____ □ Completed Suspicious Injury Report/date:_____ □ Referred to domestic violence shelter/date:_____ □ Referred to local law enforcement agency/date:_____ □ Reviewed/discussed STT PSY: □ *Spousal/Intimate Partner Abuse*_____ □ ***Cycle of Violence*** □ ***Safety When Preparing to Leave*** □ *Child Abuse and Neglect* (if under age of 18)/date:_____ □ Referred to LA County Domestic Violence Hotline: 1-800-978-3600/date:_____ or the National Domestic Violence Hotline: 1-800-799-7233/date:_____

Client Name/ID:

100. Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? 0-13 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 14-27 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 28-40 Weeks: □ No □ Yes, by whom? _____ How many times? _____	□ Reviewed/discussed STT HE: *Family Planning Choices*/date: _____ □ Referred to family planning provider/date:_____ □ Referred to social worker/date: _____ □ Referred to/date: _____
101. Within the last year, has anyone forced you to have sexual activities? 0-13 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 14-27 Weeks: □ No □ Yes, by whom? _____ How many times? _____ 28-40 Weeks: □ No □ Yes, by whom? _____ How many times? _____	
102. Are your children, or have your children ever been, victims of physical abuse, sexual abuse, or neglect? □ N/A □ No □ Yes, please explain:_____	Intervention/referral: □ Notified provider: _____ □ Contacted LA County Child Protection Hotline: 1-800-540-4000/date: _____ □ Child Abuse Report filed/date: _____ □ Reviewed/discussed STT PSY: *Child Abuse and Neglect* □ Referred to/date:_____

Initial Assessment Completed By:__

Name & CPSP Title Date Minutes

2nd Trimester Reassessment Completed By:__

Name & CPSP Title Date Minutes

3rd Trimester Reassessment Completed By:__

Name & CPSP Title Date Minutes

Client Name/ID:

Provider Signature: _____ Date: _____

Client Strengths: _____

_____

Prenatal Individualized Care Plan Summary

#	Problem/Risk/Concern	Client Goal	Updates & Outcomes
			2
			3
			P
			2
			3
			P
			2
			3
			P
			2
			3
			P
			2
			3
			P

Client Name/ID:

CPSP Progress Note

Each entry must include date, time (in minutes), staff signature and CPSP title

Client Name/ID: