PRENATAL HEALTH ASSESSMENT

Expectant Mom Name: _____ **DOB** ___/___/___

Area # _____ **Staff Name** _____ **Intake Date** ___/___/___

PAYMENT SOURCE

- ☐ Medicaid
- ☐ Private Insurance
- ☐ Other insurance (Name) _____
- ☐ No insurance **(Start a referral form to Medicaid)**

For office use only: _____ entered in CP Family services

WIC

Is expectant mom currently enrolled? ☐Yes ☐No **(Start referral form if no)**

For office use only: _____ entered in CP Family services

MEDICAL CARE SOURCE

☐ Source for ongoing accessible medical care:

_____

(clinic name, physician name, & town)

☐ No source for ongoing accessible medical care. **(Start a referral form)**

For office use only: _____ entered in CP Family services

DENTAL CARE SOURCE

☐ Source for ongoing accessible dental care: _____

(clinic name, dentist name, & town)

☐ No source for ongoing accessible medical care. **(Start a referral form)**

For office use only: _____ entered in CP Family services

PREGNANCY

Expectant Delivery Date: ___/___/___ Expectant Mom a Teen? ☐ No ☐ Yes

Length of Pregnancy at Enrollment: _____ weeks

Is this pregnancy considered high-risk: ☐ No ☐ Yes Explain: _____

Previous Pregnancies: _____ List any concerns or complications with them: _____

Expectant Mom Name: _____ **Area #** _____

NUTRITIONAL EDUCATION
☐ Gave Health Services Newsletter & discussed

NUTRITION ASSESSMENT
Does expectant mom take prenatal vitamins? ☐ Yes ☐ No
Does expectant mom have adequate food available? ☐ Yes ☐ No (Start a referral for SNAP or food pantry)
Does expectant mom plan to breast-feed? ☐ Yes ☐ No
List any nutrition concerns, including concerns shared with mom by Health or Dental Care Provider:
_____
_____

RISK FACTORS
Are there any risk factors that may affect the pregnancy? (Start a referral for any ☑)
☐ Family Concerns ☐ Job Related Concerns ☐ Housing Concerns ☐ Abuse/Violence ☐ Substance Abuse
☐ Mental Health Concerns ☐ Other: _____ ☐ No Concerns

TRAINING/EDUCATION
Are you attending any of the following?
☐ Prenatal or birthing classes (i.e. Lamaze)
☐ Breast Feeding Classes
☐ Preparing for Baby
☐ Other: _____
Are you interested in attending any of the above? ☐ Yes ☐ No (doctor/hospital should have info)

PRENATAL EDUCATION
☐ Gave info on **text4baby** (Text Baby to 511411) for free monthly updates

HEALTH DEPARTMENT NEWBORN VISIT
☐ Informed expectant mom of newborn visit needed by health department within two weeks of birth
☐ Mom signed *Prenatal Social Service Release to Health Department*
(Send to C.O. for Health Coordinator with intake forms to notify Health Department)

PRENATAL DOCTOR VISIT
First Prenatal Doctor Visit: ___/___/___
Latest Prenatal Doctor Visit: ___/___/___
Next Prenatal Doctor Visit: ___/___/___ (Make appointment now if one is not made)

DENTAL EDUCATION
☐ Gave Tips for Good Oral Health During Pregnancy handout & discussed

DENTAL EXAM
Latest Dental Exam: ___/___/___
Next Dental Exam: ___/___/___ (Make appointment now, if exam not done within the last 12mo)

Expectant Mom Name: _____ **Area # _____**

HANDOUTS: Using the PAT Curriculum and Handout list, list dates information is given.

Fetal Development Education:					**Nutrition Education:**		
/ /	/ /	/ /			/ /	/ /	/ /
Breast Feeding Education:					**Infant Care Education:**		
/ /	/ /	/ /			/ /	/ /	/ /
Substance Abuse Prevention:					**Safe Sleep Education:**		
/ /	/ /	/ /			/ /	/ /	/ /

Assist as needed to keep scheduled appointment, documenting support on *Prenatal Health Progress Sheet*. When appointment is completed, discuss results. Briefly, log results of visit below. If in discussion, there were concerns, or referrals, make note below and assist as needed in following up on concerns.

Date of Provider Visit	**Results of Visit to Provider & concerns that require follow up or referral**

List dates of dental visits and results. If not seen within last 12 months, assist in completing a dental exam and any treatment needed. **Log status of appointments and support on *Prenatal Health Progress Sheet*.** As appointments are completed, log below per discussion with Expectant Mom.

DATE	**RESULTS of DENTAL VISIT (Exam, x-rays, fillings, cleaning, fluoride)**
	Last Dental Visit was _____

Email to Health Coordinator after intake visit – Mail copy when Progress Sheets are due – Email after birth of baby & keep original in file