# Improving Pregnancy Outcomes
# Community Health Screening

*REQUIRED*

**PLEASE PRINT CLEARLY**

**Patient ID**

## Referral Information

*Referral Date (M M – D D – Y Y)

* Referral Type: ○ Agency ○ Outreach ○ Self

* Is this a Board of Social Services Referral? ○ Yes ○ No

* Is this a DCP&P Referral? ○ Yes ○ No

Is there an open DCP&P case? ○ Yes ○ No ○ N/A

* Referral Agency

* Person Making Referral — Last Name — First Name

Phone – – Phone Extension — Email Address

## Household Information

Married? ○ Yes ○ No

# of Children in the Home

Dates of Birth of Children Needing Services — Name — Relationship

1. ___/___/___
2. ___/___/___
3. ___/___/___

## * About the Referral (choose one)

○ Preconceptional Woman
*Has no children and has never been pregnant.*

○ Interconceptional Woman
First Time Parent? ○ Yes ○ No
*Previously pregnant and not currently pregnant. (Does not matter if woman has children.)*

○ Pregnant Woman
First Time Parent? ○ Yes ○ No
In Prenatal Care? ○ Yes ○ No

○ Male
Are you a Parent? ○ Yes ○ No
First Time Parent? ○ Yes ○ No
Does your child live with you? ○ Yes ○ No

## Participant Information

*Last Name — *First Name — *Date of Birth (M M – D D – Y Y)

*Street Address — Apt # — *City

*Zip Code — *County — *Primary Phone – – — Other Phone – –

*Race (choose one)
○ Black ○ White ○ Multi-Racial ○ Asian ○ Native American ○ Alaskan/Pacific Islander ○ Other _____

*Ethnicity Hispanic ○ Yes ○ No

*Primary Language (choose one)
○ English ○ Spanish ○ Other _____

*Health Insurance (Select all that apply)
○ Medicaid PE ○ Medicare ○ Medicaid MC ○ Commercial/Private ○ NJ Family Care ○ Uninsured/Self-Pay

*MCO (choose one for Medicaid Eligibles)
○ None ○ Horizon NJ Health ○ Aetna Better Health ○ United Healthcare Community ○ AmeriGroup ○ WellCare

## Pregnancy History

○ N/A

_____ How many times have you been pregnant?
_____ How many times did your baby arrive on-time? (38 wks or more)
_____ How many times did your baby arrive too soon? (37 wks or less)
_____ How many pregnancies resulted in a termination?
_____ How many pregnancies resulted in a miscarriage? (less than 20 wks)
_____ How many pregnancies have resulted in fetal deaths/still births? (20 wks or more)
_____ How many currently living children do you have?

Date of most recent live birth ○ N/A (M M – D D – Y Y)

Infant Birthweight ___ lbs ___ oz

Current Height (Ft-Inches) ___ – ___

Current Weight (lbs)

**Smoking**

| | Yes | No |
|---|---|---|
| Are you currently smoking? | ○ | ○ |
| Does anyone smoke in your household? | ○ | ○ |

## * General Medical Information

**Has a doctor or other medical professional ever told you that you have any of the following conditions?**

| | Yes | No | Unk | On Meds | History |
|---|---|---|---|---|---|
| Allergies | ○ | ○ | ○ | ○ | ○ |
| Asthma | ○ | ○ | ○ | ○ | ○ |
| Anemia | ○ | ○ | ○ | ○ | ○ |
| Cancer | ○ | ○ | ○ | ○ | ○ |
| Blood Disorder | ○ | ○ | ○ | ○ | ○ |
| Neurological Condition | ○ | ○ | ○ | ○ | ○ |
| Depression/Mental Illness | ○ | ○ | ○ | ○ | ○ |
| Sensitive/Bleeding Gums | ○ | ○ | ○ | ○ | ○ |
| Hypertension | ○ | ○ | ○ | ○ | ○ |
| Heart Condition | ○ | ○ | ○ | ○ | ○ |
| Lung Disease | ○ | ○ | ○ | ○ | ○ |
| Diabetes | ○ | ○ | ○ | ○ | ○ |
| Lupus | ○ | ○ | ○ | ○ | ○ |
| Seizures | ○ | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ | ○ |

## * Psychosocial Risk Factors

| | Yes | No | Unk |
|---|---|---|---|
| Disabled | ○ | ○ | ○ |
| Unemployed/Inadequate Income | ○ | ○ | ○ |
| Partner is Unemployed | ○ | ○ | ○ |
| Homeless | ○ | ○ | ○ |
| Unstable Housing | ○ | ○ | ○ |
| Education <12 years | ○ | ○ | ○ |
| Currently in Foster Care | ○ | ○ | ○ |
| Transportation Problems | ○ | ○ | ○ |
| Inadequate Social Support | ○ | ○ | ○ |
| Uninsured | ○ | ○ | ○ |
| Tobacco Use | ○ | ○ | ○ |
| Alcohol Use | ○ | ○ | ○ |
| Drug Use | ○ | ○ | ○ |
| Nutritional Concerns | ○ | ○ | ○ |
| Perinatal Depression | ○ | ○ | ○ |
| Eating disorder | ○ | ○ | ○ |
| Domestic Violence | ○ | ○ | ○ |
| Low Income | ○ | ○ | ○ |
| Unplanned Pregnancy | ○ | ○ | ○ |

## Primary Care

**Where do you go when you are sick?**
○ Private Doctor/Clinic ○ Emergency Room ○ Nowhere ○ Other _____

**Where do you go for check-ups?**
○ Private Doctor/Clinic ○ Emergency Room ○ Nowhere ○ Other _____

## Exposures

| | Yes | No |
|---|---|---|
| Lead: Home built before 1978 | ○ | ○ |
| Tobacco: 2nd or 3rd Hand Smoke | ○ | ○ |

## Reproductive Life Plan

| | Yes | No |
|---|---|---|
| Are you trying to get pregnant? | ○ | ○ |
| If No, are you using contraceptives? | ○ | ○ |

**What type?** ○ Barrier ○ Implant ○ Oral ○ Other

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*REQUIRED*

**Was the family affected by Hurricane Sandy?** *(i.e. housing issues, loss of job/employment, displaced or having to relocate, etc.)* ○ Yes ○ No

**Is family Sandy Social Services Block Grant (SSBG) funded?** ○ Yes ○ No ○ Unknown

## Pregnant Clients

### Entry Into Prenatal Care

* Date of First Visit ☐☐ – ☐☐ – ☐☐ (M M – D D – Y Y)  * LMP ☐☐ – ☐☐ – ☐☐ (M M – D D – Y Y)  * EDD ☐☐ – ☐☐ – ☐☐ (M M – D D – Y Y)

Pre Pregnancy Weight (lbs) ☐☐☐

Bleeding During Current Pregnancy ○ 1st Trimester ○ 2nd Trimester ○ 3rd Trimester ○ None

### Identified Health Risks/Concerns

**Has a doctor or other medical professional ever told you that you have any of the following conditions?**

| | Current Preg Y | N | Unk | Prior Preg Y | N |
|---|---|---|---|---|---|
| Abnormal Pap | ○ | ○ | ○ | ○ | ○ |
| Cervical Incompetence | ○ | ○ | ○ | ○ | ○ |
| Ectopic Pregnancy | ○ | ○ | ○ | ○ | ○ |
| Gestational Diabetes | ○ | ○ | ○ | ○ | ○ |
| Group B Strep | ○ | ○ | ○ | ○ | ○ |
| Hepatitis B | ○ | ○ | ○ | ○ | ○ |
| Low Birth Weight (<2500gm) | na | na | na | ○ | ○ |
| Multiple Gestation | ○ | ○ | ○ | ○ | ○ |
| Obesity | ○ | ○ | ○ | ○ | ○ |
| Opioid Replacement Tx | ○ | ○ | ○ | ○ | ○ |
| PIH/Preeclampsia | ○ | ○ | ○ | ○ | ○ |
| Previous Cesarean Section | na | na | na | ○ | ○ |
| Rh Negative | ○ | ○ | ○ | ○ | ○ |
| STD | ○ | ○ | ○ | ○ | ○ |
| Uterine Abnormalities | ○ | ○ | ○ | ○ | ○ |

### *4Ps Plus

| | Yes | No |
|---|---|---|
| Did either of your parents have a problem with drugs or alcohol | ○ | ○ |
| Does your partner have any problem with drugs or alcohol | ○ | ○ |
| Have you ever felt manipulated by your partner | ○ | ○ |
| Have you ever felt out of control or helpless | ○ | ○ |
| Over the past 2 weeks | | |
| have you felt down, depressed or hopeless | ○ | ○ |
| have you felt little interest or pleasure in doing things | ○ | ○ |

| | Yes | No |
|---|---|---|
| Have you ever drunk beer/wine/liquor | ○ | ○ |

| In the month before you knew you were pregnant | *Any | None |
|---|---|---|
| how many cigarettes did you smoke | ○ | ○ |
| how much beer/wine/liquor did you drink | ○ | ○ |
| how much marijuana did you use | ○ | ○ |

***If an *Any is checked, continue with the 4Ps Follow-Up Questions.**

### 4 Ps Plus Follow-up Questions (if an *Any above was checked)

| In the month before you knew you were pregnant | Refer for Assessment: Every Day | Refer for Assessment: 3-6 Days/wk | Prevention Education: 1-2 days/wk | Prevention Education: <1 day/wk | No Referral Needed (did not drink/use drugs) |
|---|---|---|---|---|---|
| About how many days a week ***did you*** usually drink beer / wine / liquor | ○ | ○ | ○ | ○ | ○ |
| use any drug such as marijuana, cocaine or heroin | ○ | ○ | ○ | ○ | ○ |
| And now, about how many days a week ***do you*** usually drink beer / wine / liquor | ○ | ○ | ○ | ○ | ○ |
| use any drug such as marijuana, cocaine or heroin | ○ | ○ | ○ | ○ | ○ |

### Referrals/Education

**Please complete for ALL clients**

| | Referred | Receiving Service | Referral Needed | Refused | Not Needed |
|---|---|---|---|---|---|
| Tobacco Cessation | ○ | ○ | ○ | ○ | ○ |
| Substance Abuse Prevention Ed | ○ | ○ | ○ | ○ | ○ |
| Substance Abuse Assessment | ○ | ○ | ○ | ○ | ○ |
| Mental Health Assessment | ○ | ○ | ○ | ○ | ○ |
| Domestic Violence Assessment | ○ | ○ | ○ | ○ | ○ |
| TANF/GA | ○ | ○ | ○ | ○ | ○ |
| Emergency Assistance | ○ | ○ | ○ | ○ | ○ |
| Food Stamps | ○ | ○ | ○ | ○ | ○ |
| WIC | ○ | ○ | ○ | ○ | ○ |
| Dentist | ○ | ○ | ○ | ○ | ○ |
| Prenatal Care | ○ | ○ | ○ | ○ | ○ |
| Primary Care Participant | ○ | ○ | ○ | ○ | ○ |
| Primary Care Child | ○ | ○ | ○ | ○ | ○ |
| SSI | ○ | ○ | ○ | ○ | ○ |
| DCP&P | ○ | ○ | ○ | ○ | ○ |
| Preterm Labor Prevention | ○ | ○ | ○ | ○ | ○ |
| Diabetes Care Program | ○ | ○ | ○ | ○ | ○ |
| Nutritional Consult | ○ | ○ | ○ | ○ | ○ |
| Breast Feeding Consult | ○ | ○ | ○ | ○ | ○ |
| Childbirth Education | ○ | ○ | ○ | ○ | ○ |
| *Community Based Services | ○ | na | na | ○ | ○ |

** Includes referrals to local Community Health Worker, Community Home Visiting, and other supportive services.*

**PLEASE PRINT CLEARLY**

**Notes**

*** Participant Consent**

I agree to provide the information regarding my health and social service needs for review and screening in order to have appropriate available Community Based Services contact me.
I agree to be contacted by program staff to follow-up with me or the agency to which I was referred.

**Oral Consent Given** ○ Yes ○ No  *Sign here* _____

*Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.*