# Combined Initial Assessment and Individualized Care Plan

❑ **Orientation completed, per protocol: Minutes_______**

## Psychosocial

Patient Identifier

1. **Pregnancy Information**
   DOB _____________ Age _______________
   EDC _____________ Wks. Gestation ______
   Grav _______Para _______TAB _______ SAB _______

2. Problems with previous pregnancies? ❑ N/A ❑ No
   ❑ Yes, describe:

3. Current medical problems? ❑ No
   ❑ Yes, describe:

4. Planned pregnancy? ❑ Yes
   ❑ No, describe:

5. Wanted pregnancy? ❑ Yes
   ❑ No, describe:

   Considering abortion/adoption? ❑ No
   ❑ Yes, describe:

6. Previous pregnancy loss/infant death? ❑ N/A ❑ No
   ❑ Yes, describe:

7. FOB/partner accepts pregnancy? ❑ Yes
   ❑ No, describe:

**Family/Support System**

8. Members of household (not including patient)
   number of adults: ______
   relationship to patient:

   number of children: ______
   relationship to patient:

9. Patient's children all live with her? ❑ N/A ❑ Yes
   ❑ No, describe:

10. Patient turns to for emotional support:
    ❑ FOB/partner ❑ family member: _______________
    ❑ friend: _______________ ❑ other: ________________
    ❑ no one, describe:

**Emotional Concerns**

11. Currently having any personal or family problems that are troubling you? ❑ No
    ❑ Yes, describe:

12. Do you often feel:
    down, depressed or hopeless? ❑ No
    ❑ Yes, describe:

    irritable, restless or anxious? ❑ No
    ❑ Yes, describe:

13. Have you lost interest or pleasure in doing things that you used to enjoy? ❑ No
    ❑ Yes, describe:

14. Ever seen a counselor for personal or family problems? ❑ No
    ❑ Yes, describe:

15. Currently receiving services from a local agency such as case management, counseling etc.? ❑ No
    ❑ Yes, describe:

**Domestic Violence**

16. Ever been emotionally, physically, or sexually abused by a partner or someone close to you? ❑ No
    ❑ Yes, describe:

17. Within the last year ever been hit, slapped, kicked, pushed, shoved, forced to have sex or otherwise physically hurt by partner or ex-partner? ❑ No
    ❑ Yes, describe:

18. Afraid of partner or ex-partner? ❑ No
    ❑ Yes, describe:

19. Guns or other weapons in the home? ❑ No
    ❑ Yes, describe:

**Employment/Finances**

20. Source of financial support:
    ❑ self, type of work: _____________________________
    ❑ FOB/partner, type of work: ______________________
    ❑ family member:__________ ❑ friend:____________
    ❑ CalWORKS ❑ SSI ❑ other: _____________
    ❑ problems:

**Housing**

21. Type of housing:
    ❑ apartment/house ❑ other: _______________
    ❑ problems:

22. **Goals for this pregnancy**: ❑ healthy baby
    ❑ other:

| Risks/Concerns | No | Yes | Psychosocial Individualized Care Plan |
|---|---|---|---|
| 1. Teen parent<br>(STT PS Teen Pregnancy and Parenting) | N | Y | ❑ Referred to: |
| 1. Late entry to prenatal care (after 16 weeks) | N | Y | ❑ Stressed importance for consistent prenatal care |
| 3. Current medical problems | N | Y | ❑ Consult with ob provider ❑ Provided emotional support |
| 5. Unwanted pregnancy<br>(STT PS Unwanted Pregnancy) | N | Y | ❑ Consult with ob provider<br>❑ Referred to: |
| 6. Previous pregnancy/infant loss<br>(STT PS Emotional or Mental Health Concerns) | N | Y | ❑ Provided emotional support<br>❑ Referred to: |
| 7. FOB/partner does not accept pregnancy | N | Y | ❑ Provided emotional support<br>❑ Referred to: |
| 9. Not all of patient's children live with her | N | Y | ❑ Provided emotional support<br>❑ If history of abuse/neglect, referred to: |
| 10. Poor emotional/social support | N | Y | ❑ Provided emotional support<br>❑ Referred to: |
| 11. Current personal or family problems<br>(STT PS Emotional or Mental Health Concerns) | N | Y | ❑ Provided emotional support<br>❑ Referred to: |
| 12.-14. Current/past emotional problems<br>(STT PS Emotional or Mental Health Concerns) | N | Y | ❑ Provided emotional support<br>❑ Assess for signs of emotional concerns at future appointments<br>❑ Reviewed *Are You Feeling Sad…?*<br>❑ Consult with ob provider<br>❑ Referred to: |
| 15. Receiving services from local agency such as case management, counseling etc. | N | Y | ❑ Obtained patient's written permission to coordinate care with:<br>Agency:<br>Contact person:<br>Phone: Fax: |
| 17.-18. Current domestic violence<br>(STT PS Spousal/Partner Abuse) | N | Y | If current injuries, ❑ Referred to ob provider ❑ Reported to law enforcement<br>❑ Discussed cycle of violence ❑ Assessed safety ❑ Reviewed legal options<br>❑ Referred to: |
| 19. Weapons in the home | N | Y | ❑ Discussed safety precautions |
| 20. Financial problems<br>(STT PS Financial Concerns) | N | Y | ❑ Referred to: |
| 21. Housing problems<br>(STT PS Financial and/or Legal/Advocacy) | N | Y | ❑ Referred to: |
| Other risk or concern | N | Y | ❑ Referred to: |

# Combined Initial Perinatal Assessment and Individualized Care Plan

## Health Education

Patient Identifier

23. English language:

| | | Poor | Fair | Good |
|---|---|---|---|---|
| speaking | | ❑ | ❑ | ❑ |
| writing/reading | ❑ non-reader | ❑ | ❑ | ❑ |

24. Other language: ________________________ ❑ N/A

| | | Poor | Fair | Good |
|---|---|---|---|---|
| speaking | | ❑ | ❑ | ❑ |
| writing/reading | ❑ non-reader | ❑ | ❑ | ❑ |

25. Likes to learn by:
❑ reading/handouts ❑ classes/groups
❑ individual teaching ❑ videos
❑ other:

26. Last grade completed:________ ❑ 12th or over

27. Any disabilities that affect ability to learn? ❑ No
(such as vision, hearing, developmental delays)
❑ Yes, describe:

28. Born in the United States: ❑ Yes
❑ If not, country of birth: _____________________
length of time living in US: ________months/years

29. Ever used health care services in U.S.? ❑ Yes
❑ No, comments:

30. Dental check-up within past 12 months? ❑ Yes
❑ No, comments:

31. Any dental problems? ❑ No
❑ Yes, comments:

32. Transportation to clinic: ❑ bus ❑ car ❑ walk
❑ taxi ❑ other:
❑ problems:

33. Knows how to use seat belt when pregnant? ❑ Yes
❑ No

34. Previous knowledge/experience with:

| | | |
|---|---|---|
| pregnancy | ❑ No | ❑ Yes |
| prenatal care | ❑ No | ❑ Yes |
| delivery/postpartum self-care | ❑ No | ❑ Yes |
| infant care and safety | ❑ No | ❑ Yes |

35. Person to share in your prenatal education? ❑ Yes
❑ No, comments:

36. Who gives advice about being pregnant?
❑ mother ❑ mother-in-law ❑ friend: _____________
❑ partner ❑ grandmother ❑ other: ______________

37. What are the most important things they have advised?

38. Exposed to dangers at work or home such as ❑ No
❑ chemicals, paints, polishes, pesticides, lead
❑ cats ❑ rodents
❑ hot baths ❑ x-rays ❑ douching
❑ other:___________________________

39. Did your parents have problems with drugs or alcohol? ❑ No
❑ Yes, describe:

40. Does your partner have problems with drugs or alcohol? ❑ NA ❑ No
❑ Yes, describe:

41. Before you knew you were pregnant, how much beer/wine/liquor did you drink? ❑ None
❑ was drinking ____ (amount) _________________ (type of liquor) a day/wk/month
❑ now drinking ____ (amount) _________________ (type of liquor) a day/wk/month

How often do you drink a lot at one time? ❑ Never
(4 or more drinks in about 2 hours)
____ (times) a day/wk/month

42. Before you knew you were pregnant, how much did you smoke? ❑ None
❑ was smoking ________ cigarettes a day
Now
❑ stopped smoking and is not smoking now
❑ cut down on the number of cigarettes to ____ a day
❑ smoking about the same number of cigarettes a day

43. Exposed to 2nd hand smoke at home/elsewhere? ❑ No
❑ Yes, about _______ (number) hours per day

44. Before you knew you were pregnant, how much did you usually use marijuana or other drugs? ❑ None
❑ was using _____ (amount) _________________ (drug) a day/wk/month
❑ now using ____ (amount) _________________ (drug) a day/wk/month

| Patient interested in learning: | No | Yes | Health Education Individualized Care Plan |
|---|---|---|---|
| Body changes during pregnancy/baby's growth | N | Y | ❑ Discussed ❑ Will discuss later |
| Danger signs, preterm labor, kick counts (STT HE Preterm Labor) | N | Y | Reviewed STT HE ❑ *Danger Signs* ❑ *If Labor Starts Too Early* ❑ Consult with ob provider ❑ Used *Kick Counts* handout if more than 28 wks. |
| Family planning (STT HE Family Planning Choices) | N | Y | ❑ Will discuss later |
| STDs (STT HE STIs) | N | Y | Reviewed STT HE ❑ *What You Should Know About STDs* ❑ *Protect Yourself from STDs* ❑ Consult with ob provider re: ❑ Will discuss later |
| Other: | N | Y | ❑ Will discuss later |
| **Patient's educational needs** | | | |
| Dental care/problems (STT HE Oral Health During Pregnancy) | N | Y | Reviewed STT HE ❑ *Prevent Gum Problems* ❑ *See a Dentist* ❑ *Keep Teeth Healthy* ❑ Consult with ob provider ❑ Completed Prenatal Dental Referral ❑ Referred to: |
| Lack of transportation | N | Y | ❑ Referred to: |
| Seat belt use | N | Y | ❑ Demonstrated safe seat belt use Reviewed ❑ *What's the Right Way…* |
| Following harmful advice | N | Y | ❑ Consult with ob provider re: |
| Exposed to Dangers (STT HE Cautions, Cause for Concern and/or Workplace and Home Safety) | N | Y | Reviewed ❑ *Steps for a Healthy Baby* ❑ Consult with ob provider re: |
| Parent/partner drug/alcohol use | N | Y | ❑ Continue to assess for effect on patient ❑ Referred to: |
| Patient recently quit alcohol use | N | Y | ❑ Reinforced patient's decision not to drink alcohol |
| Patient current alcohol use (STT PS Perinatal Substance Abuse) | N | Y | ❑ Advised of risks ❑ Consult with ob provider ❑ Support person: ❑ Agreed to cut down/quit: ❑ Referred to: |
| Patient recently quit smoking | N | Y | ❑ Reinforced patient's decision not to smoke Reviewed ❑ *You Can Quit Smoking (Support and Advice)* |
| Patient currently smoking (STT HE Tobacco Use) | N | Y | ❑ Advised of risks ❑ Consult with ob provider ❑ Reviewed *You Can Quit Smoking (Support and Advice)* ❑ Agreed to quit (date)______ ❑ Will cut down to ____ per day ❑ Faxed referral to CA Smokers' Helpline ❑ Referred to: |
| Second-hand smoke (STT HE Secondhand Smoke) | N | Y | ❑ Advised to avoid second-hand smoke ❑ Pt. will talk to others about keeping home/car smoke-free |
| Patient recently quit drug use | N | Y | ❑ Reinforced patient's decision not to use any drugs ❑ Support person: |
| Patient current drug use (STT PS Perinatal Substance Abuse) | N | Y | ❑ Advised of risks ❑ Consult with ob provider Reviewed ❑ *Marijuana and Pregnancy* ❑ Support person: ❑ Agreed to cut down/quit: ❑ Referred to: ❑ Obtained pt's written permission to coordinate care with drug treatment agency: case manager: phone: |

**Barriers to Learning** ❑ none
- ❑ difficulty in reading
- ❑ mental/emotional disability affecting learning
- ❑ vision/hearing problem (uncorrected) affecting learning
- ❑ little experience with Western health care
- ❑ low interest in learning
- ❑ other: ________________________________________

**Health Education Strengths**
- ❑ completed 12th grade or more
- ❑ some experience with pregnancy/delivery/infant care
- ❑ social support for prenatal education
- ❑ interested in learning
- ❑ other:__________________________________________

# Combined Initial Perinatal Assessment and Individualized Care Plan

Patient Identifier

## Nutrition

45. Weight pre-pregnancy: ______ lbs. Height _____ inches
    Weight gain category is:
    ❑ Underweight ❑ Normal
    ❑ Overweight ❑ Obese
46. Today's weight _________ lbs.
    Weight gain to date this pregnancy: ________ lbs.
    Based on above, recommended weight gain is:
    ❑ Underweight 28-40 lbs.
    ❑ Normal 25-35 lbs.
    ❑ Overweight 15-25 lbs.
    ❑ Obese 11-20 lbs.
47. Weight gain plotted on appropriate grid ❑ Yes
48. Reviewed patient's *My Healthy Weight Gain.* ❑ Yes
49. Current weight gain appropriate? ❑ Yes
    ❑ No, excessive weight gain
    ❑ No, inadequate weight gain
50. Completed the Perinatal Dietary Assessment with patient's *My Healthy Eating Plan* ❑Yes
51. Number of times per day usually eats?
    1 2 3 4 5 6 7 or more
52. Allergic to foods? ❑ No
    ❑ Yes, describe:
53. Any foods or food groups avoided? (such as meat or dairy) ❑ No
    ❑ Yes, list which foods and note reason:
54. Ever eat raw or undercooked eggs/seafood/meat? ❑ No
    ❑ Yes, describe:
55. Ever eat deli meats or hot dogs? ❑ No
    ❑ Yes, describe:
56. Ever eat soft cheeses such as feta, blue cheese, queso de crema, asadero, queso fresco or panela? ❑ No
    ❑ Yes, describe:
57. Do you eat more than 12 oz. of fish each week? ❑ No
    ❑ Yes, describe:
58. Ever eat fish caught by friends or family ❑ No
    ❑ Yes, describe:
59. Food or non-food cravings? ❑ No
    (non-foods such as ice, plaster, cornstarch, dirt, clay, laundry starch)
    ❑ Yes, describe:
60. Current discomforts? ❑ No
    ❑ nausea ❑ vomiting ❑ edema ❑ diarrhea
    ❑ heartburn ❑ constipation ❑ other: ____________
61. Nutrition-related medical conditions? ❑ No
    (such as diabetes, hypertension)
    ❑ Yes, describe:
62. Knowledge or experience with breastfeeding?
    ❑ no knowledge or experience
    ❑ observed friends/family ❑ took class
    ❑ personal experience? Circle and comment:
    negative none positive
63. Planning to breastfeed? ❑ Yes
    ❑ No ❑ Combine with formula ❑ Not sure
64. Currently taking prenatal vitamins? ❑ Yes
    ❑ No, needs vitamins:
65. Currently taking (if yes; type, amount, frequency): ❑ None
    In addition to prenatal vitamins:
    ❑ over-the-counter drugs:
    ❑ prescription medications:
    ❑ dietary supplements:
    ❑ home remedies:
    ❑ other:
66. Already enrolled in WIC? ❑ Yes
    ❑ WIC, site: ____________________
    ❑ No, needs referral
67. Ever run out of food? ❑ No
    ❑ Yes, describe:
68. Have access to a working kitchen? ❑ Yes
    ❑ No. Way to cook food? Describe:

    ❑ No. Refrigerator to store food? Describe:
69. Physically active at least 3 times each week?
    ❑ Yes, comment:

    ❑ No, comment:

| Risks/Dietary Issues | No | Yes | Nutrition Individualized Care Plan |
|---|---|---|---|
| 46. Weight gain recommended | all patients | | ❑ 28-40 lbs. ❑ 25-35 lbs. ❑ 15-25 lbs. ❑ 11-20 lbs. |
| 47. Weight gain inappropriate<br>(STT N Weight Gain) | N | Y | Reviewed STT N ❑ *Tips To Gain Weight* ❑ *Tips to Slow Weight Gain*<br>❑ Consult with ob provider re:<br>❑ Referred to: |
| 51. Eats less than 3 times/day | N | Y | ❑ Advised to eat every 3-4 hours ❑ Discussed reason for infrequent eating<br>❑ Referred to: |
| 52. Food allergies | N | Y | ❑ No major impact on food intake ❑ Consult with ob provider re:<br>❑ Referred to: |
| 53. Avoids major food groups<br>(STT N Lactose Intolerance, Vegetarian Eating) | N | Y | Reviewed STT N ❑ *Vegetarian Eating* ❑ *Choose Healthy Foods*<br>❑ *Trouble with Milk Foods* ❑ *Foods Rich in Calcium* |
| 54.-58. Food safety issues<br>(STT N Food Safety) | N | Y | Reviewed ❑ *Steps for a Healthy Baby*<br>Advised patient:<br>❑ not eat raw or undercooked meat /seafood/ eggs<br>❑ not to eat hot dogs, luncheon meats or deli meats unless reheated to steaming hot<br>❑ not to eat soft cheeses unless labels show that they are pasteurized<br>❑ not to eat shark, swordfish, tilefish or king mackerel<br>❑ not to eat more than 12 oz. of other kinds of fish per week<br>❑ to check local fish advisories if eating fish caught by friends and family<br>❑ Consult with ob provider re: |
| 59. Food or non-food cravings<br>(STT N Pica) | N | Y | ❑ No negative impact on food intake<br>❑ Consult with ob provider |
| 60. Current discomforts<br>(STT N Nausea and Vomiting, Heartburn, Constipation) | N | Y | Reviewed STT N ❑ *Nausea* ❑ *Vomiting* ❑ *Heartburn* ❑ *Antacids*<br>❑ *Constipation* ❑ *Products for Constipation*<br>❑ Consult with ob provider re: |
| 61. Nutrition-related medical conditions<br>(STT N Anemia, Prenatal Vitamins/Minerals) | N | Y | Reviewed STT N ❑ *Iron Pills* ❑ *Extra Calcium*<br>❑ Consult with ob provider re:<br>❑ Refer to: |
| 62.-63. Breastfeeding/infant feeding education<br>(STT N Breastfeeding) | all patients | | ❑ Discussed breastfeeding benefits<br>Reviewed STT N ❑ *Getting Started with Breastfeeding* |
| 64. Prenatal vitamins<br>(STT N Prenatal Vitamins) | all patients | | Reviewed STT N ❑ *Prenatal Vitamins* |
| 65. Medicines/supplements/ home remedies | N | Y | ❑ Advised pt. to check with ob provider before taking any drugs, medicines or herbs<br>❑ Consult with ob provider re: |
| 66.-67. Food access<br>(STT N Stretch Your Food Dollar and/or PS Financial Concerns) | all patients | | Reviewed STT N ❑ *Shopping Tips* ❑ *Stretch Your Dollars*<br>❑ *Low-Cost Healthy Foods*<br>Referred to: ❑ WIC site: ________________ ❑ Food Stamps<br>❑ Emergency Food Box |
| 68. Food preparation/storage problem<br>(STT N Cooking and Food Storage) | N | Y | Reviewed STT N ❑ *Tips for Cooking / Storing Foods* ❑ *When You Cannot Refrigerate* |
| 69. Physical activity<br>(STT HE Safe Exercise and Lifting) | all patients | | ❑ Advised to engage in physical activity least 3 times/week<br>Reviewed STT HE ❑ *Stay Active When You are Pregnant*<br>❑ *Keep Safe When You Exercise* |
| Other risk/dietary issue: | N | Y | |

**Labs** ketones + - glucose + - protein + - BP _______ Hgb ________ Hct _______

❑ Problematic lab values; coordinate care with OB provider

**Comments:** ______________________________________________________________________

**Completed by:** ______________________________________________ __________ __________

Signature Title Date Orientation Minutes Assessment Minutes

**Reviewed by medical provider if assessor is CPHW:**______________________________________________

Signature Title Date