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 ☐ Medicaid MC ☐ NJ Family Care ☐ Medicare ☐ Commercial/Private ☐ Uninsured/Self-Pay

*MCO (choose one for Medicaid Eligibles)
○ None ○ Aetna Better Health ○ AmeriGroup ○ Horizon NJ Health ○ United Healthcare Community ○ 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		Current Preg Y	N	Unk	Prior Preg Y	N		Current Preg Y	N	Unk	Prior Preg Y	N
Abnormal Pap	○	○	○	○	○	Hepatitis B	○	○	○	○	○	PIH/Preeclampsia	○	○	○	○	○
Cervical Incompetence	○	○	○	○	○	Low Birth Weight (<2500gm)	na	na	na	○	○	Previous Cesarean Section	na	na	na	○	○
Ectopic Pregnancy	○	○	○	○	○	Multiple Gestation	○	○	○	○	○	Rh Negative	○	○	○	○	○
Gestational Diabetes	○	○	○	○	○	Obesity	○	○	○	○	○	STD	○	○	○	○	○
Group B Strep	○	○	○	○	○	Opioid Replacement Tx	○	○	○	○	○	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	○	○	○	○	○

	Referred	Receiving Service	Referral Needed	Refused	Not Needed
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.