# Comprehensive Perinatal Services Program (CPSP) / Perinatal Support Services Program (PSS)

**POLICY:**

PMG/Health Plan/Medi-Cal shall ensure that CPSP/PSS services are available to all pregnant women. Provider network and Medical Management will track evidence that provider and staff are educated on Medi-cal programs.

**PROCEDURE:**

- Referral Process
  - At the time a request for total OB care is received, staff shall ensure that a Pregnancy Notification Report (PNR) is received and forwarded to Health Plan / Medi-Cal. Health Plan / Medi-Cal is responsible to refer the member to contracted PSD provider.
  - If the member refuses to participate the contracted PSS provider will notify Health Plan / Medi-Cal and the provider. The provider is required to document the refusal in the members medical record and provide the member with the following:
    - Pregnancy education materials
    - Breastfeeding education and materials
    - A referral to WIC and other community resources, as needed.
  - A request for total OB care falls under the auto approval policy and procedure.
  - The referral coordinator will the appropriate data from the PNR on the applicable Birth Outcome Report.
  - If the PNR is not received with the total OB request the referral coordinator will phone the provider office.
- Available CPSP/PSS Services
  - Initial assessment with evaluation of risk factors.
  - Nutritional services.
  - Health education.
  - Psychosocial services.
  - Additional referrals as needed.
  - Postpartum assessment.
- Case Management
  - Case management services shall be made available to all high risk pregnant members.
  - PMG's case manager shall assist if needed with coordination of care with the members OB provider.
  - Case management and the provider shall offer services that enhance the member's health and level of independence including but not limited to, coordination of carve out services, referrals to community resources, an initial health assessment with evaluation of risk factors, nutritional services, health education, psychosocial services, referral to appropriate specialists including perinatologists, postpartum assessment.

- Using information from the risk assessment tool, the vendor shall develop an individualized treatment plan and provide case coordination services to the member according to the American College of Obstetricians and Gynecologists (ACOG) standards.
- The case manager will receive activity reports from the PSS/CPSP vendors which will be reviewed and data will be updated on the Birth Outcome Log. Reports will be reviewed for one-on-one education, health education sessions and/or referrals to health education, and referrals to specialty care services.
    - Health education data will also be logged on the internal health education tracking log.
        - First trimester initial assessments will be applied to a referral attendance for prenatal education.
        - Second and third trimester re-assessments will be applied to attendance for prenatal education.
        - Postpartum assessments will be applied to attendance for family planning and parenting attendance.

- The OB/GYN provider shall offer the member comprehensive HIV information, counseling, testing, and referral services as required by State Law. The provider shall maintain medical records documenting these services.
- The OB/GYN provider shall refer applicable members to WIC. This information shall be documented in the member's medical record.
- A child abuse report shall be filed if necessary. This information shall be documented in the member's medical record.
- CPSP Reporting
    - A Postpartum and Poor Outcome Notification Report will be faxed to Health Plan/Medi-Cal within 7 calendar days after an occurrence.
    - PMG shall submit a quarterly Birth Outcome report to the Health Plan and Medi-Cal. Areas reported include but are not limited to:
        - Number of Medi-Cal pregnant members.
        - Pregnant members offered CPSP/PSS services.
        - Pregnant members who have accepted or refused CPSP/PSS services.

# COMPREHENSIVE PERINATAL SERVICES PROGRAM
## Assessment Risk/Strength Summary

### Instructions for Use

The Assessment Risk/Strength Summary is designed to be used as a summary of risk/strengths identified on a completed State Initial Combined Assessment (CDPH 4455). The form may be completed by any qualified Comprehensive Perinatal Services Program (CPSP) practitioner, as defined in Title 22, Section 51179. The use of this summary sheet is optional.

### Purpose

The Assessment Risk/Strength Summary sheet provides a quick visual summary of the risks and strengths of a CPSP client, as identified at the completion of the initial assessment. It is ***not*** a substitute for the Individual Care Plan. The summary has several potential uses, for example:

- Together, the client and practitioner can review risks and strengths, identify priorities, and develop an Individual Care Plan;
- The form, with prior approval, could be used as documentation for a managed care plan of a client's risk and need for interventions;
- Used as a data summary sheet, with information compiled, analyzed, and tracked over time to give a picture of the needs of the clients for a particular practice site.

### Procedures/Documentation

The Assessment Risk/Strength Summary sheet is approved to be completed by any qualified CPSP practitioner.

1. Inform the client of the purpose for completing the summary (this may vary by practice setting).
2. Review each section of the Initial Combined Assessment (CDPH 4455) and complete the applicable information in the corresponding section of the summary document.
3. For each section, identify client strengths and document them on the form.
4. Most sections have space to identify other risks that are not already listed on the form; document as necessary.
5. Store document as specified for the practice site.

# ASSESSMENT RISK/STRENGTH SUMMARY

(To be used in conjunction with CDPH 4455, Initial Combined Assessment)

**Personal Information**
Age: ❒ <12 yr. ❒ 12–17 yr. ❒ 35+ yr.
Resident: ❒ <1 yr.
❒ Children living out of home
❒ _____
Strengths: _____

**Economic Resources**
❒ No financial support from FOB
❒ Insufficient food supplies
❒ Needs WIC referral
❒ _____
Strengths: _____

**Housing**
❒ Transient housing
❒ Substandard housing
❒ No phone ❒ Message phone
❒ Weapons in home
Strengths: _____

**Transportation**
❒ No reliable transportation
❒ Needs referral for infant car safety seat
❒ No seat belt use
❒ _____
❒ _____
❒ _____
Strengths: _____

**Current Health Practices**
❒ Needs dental care
❒ Medication use since LMP
❒ Chemical exposure
❒ Poor HX using health care system
❒ _____
❒ _____
❒ _____
Strengths: _____

**Pregnancy Care**
❒ Ambivalent about pregnancy
❒ Unwanted pregnancy
❒ Lacks support for pregnancy, L&D, postpartum
❒ Using natural remedies
❒ HX pregnancy/child losses
❒ HX STI self/partner
❒ Needs referral for discomforts of pregnancy
Strengths: _____

**Nutrition**
❒ Anthropometric data outside of NL: _____
❒ Biochemical data outside of NL: _____
❒ Clinical conditions outside of NL: _____
❒ Poor appetite
❒ PICA
❒ Special diet: _____
❒ Inappropriate vitamin/mineral use
❒ Unusual dietary practices

❒ HX or current eating disorder
❒ Inadequate diet (24-Hour Recall)
❒ Inappropriate weight gain (grid)
❒ Excessive caffeine intake
Strengths: _____

**Infant Feeding**
❒ Has never breast-fed
❒ HX problem with breast feeding
❒ Lacks support for breast feeding
Strengths: _____

**Coping Skills**
❒ Experiencing significant life stressors
❒ HX domestic violence
❒ Victim of violence/sexual abuse: self/children/parents
❒ HX suicidal ideation/attempt
❒ Depression
❒ Inadequate support system
❒ _____
❒ _____
Strengths: _____

**Tobacco, Drug, Alcohol Use**
❒ Uses tobacco
❒ Current HX alcohol use/abuse
❒ Current HX drug use/abuse
❒ Partner uses/abuses drugs/alcohol
Strengths: _____

**Education and Language**
Education: ❒ <8 yr. ❒ 9–11 yr.
❒ Non-English-speaking/reading
❒ Low literacy skills
❒ _____
Strengths: _____

**Educational Interests**
❒ Barriers to attending classes
❒ Mental, emotional, or physical conditions affecting learning
❒ _____
Strengths: _____

**Obstetrics**
❒ Diabetes, gestational/overt
❒ Chronic/high risk medical condition
❒ VBAC, repeat C-Section
❒ Multiple gestation
❒ Short pregnancy interval

❒ Late entry to care
❒ Hypertension/PIH
❒ Hyperemesis
❒ Urinary tract infection
❒ Underweight/obese pre-pregnancy
❒ Hx preterm labor

❒ Hepatitis B+/HIV+
❒ Rubella negative
❒ Religious restrictions to procedures
❒ _____
❒ _____
❒ _____

# COMPREHENSIVE PERINATAL SERVICES PROGRAM

Name
Birth date
I.D. number
EDD

## INITIAL COMBINED ASSESSMENT

### PERSONAL INFORMATION

1. Your name: _____
2. Age: ❒ Less than 12 years ❒ 12–17 years ❒ 18–34 years ❒ 35 years or older
3. Place of birth: _____
4. How long have you lived in this area? ❒ Less than 1 year ❒ 1–5 years ❒ 5+ years ❒ Life
5. Do you plan to stay in this area for the rest of your pregnancy? ❒ Yes ❒ No
6. Are you: ❒ Married ❒ Single ❒ Divorced/separated ❒ Widowed ❒ Other: _____
7. Who lives with you in your home?

| Name | Relation | Age | Name | Relation | Age |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

8. Do any of your children or your partner's children live with someone else? ❒ Yes ❒ No ❒ N/A
   If yes, explain: _____

### ECONOMIC RESOURCES

9. Are you currently working? ❒ Yes ❒ No If yes, type of work and hours per week: _____
10. Do you plan to return to work after the baby is born? ❒ Yes ❒ No
11. Will the father of the baby provide financial support to you and the baby? ❒ Yes ❒ No
12. Are you receiving any of the following: (Check all that apply.)

| | Yes | No | Needs Information/ Referral |
|---|---|---|---|
| a. WIC | ❒ | ❒ | ❒ |
| b. Food stamps | ❒ | ❒ | ❒ |
| c. AFDC | ❒ | ❒ | ❒ |
| d. Emergency food assistance | ❒ | ❒ | ❒ |
| e. Pregnancy-related disability insurance benefits | ❒ | ❒ | ❒ |

13. Do you have enough clothes for yourself and your family? ❒ ❒
14. Do you or others in your home skip meals due to lack of money? ❒ ❒

### HOUSING

15. What type of housing do you currently live in?
    ❒ Apartment ❒ House ❒ Hotel/motel ❒ Emergency shelter ❒ Public housing
    ❒ Trailer park ❒ Car ❒ Farm worker camp ❒ Other: _____

Name
Birth date
I.D. number
EDD

16. Do you have the following where you live? (Check all that apply.)

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Tub/shower | ❒ | ❒ | Stove | ❒ | ❒ | Telephone | ❒ | ❒ |
| Electricity | ❒ | ❒ | Heat | ❒ | ❒ | Hot water | ❒ | ❒ |
| Refrigerator | ❒ | ❒ | Toilet | ❒ | ❒ | Cold water | ❒ | ❒ |

17. Do you feel your current housing meets your basic needs? ❒ Yes ❒ No
18. Do you feel safe in your home? ❒ Yes ❒ No
    If no, why not? _____
19. If there are guns in your home, how are they stored? _____

**TRANSPORTATION**

20. Will you have problems keeping your appointments? ❒ Yes ❒ No
    If yes, is the problem: ❒ Transportation ❒ Child care ❒ Work ❒ School ❒ Other: _____
21. When you ride in a car, how often do you use seat belts? ❒ Always ❒ Sometimes ❒ Never
22. Will you be able to get a car safety seat for the new baby by the time it is born? ❒ Yes ❒ No

**CURRENT HEALTH PRACTICES**

23. Have you ever had trouble finding a doctor or getting necessary treatment for yourself or your family? ❒ Yes ❒ No
    If yes, please explain: _____
24. Have you been to the dentist in the last year? ❒ Yes ❒ No
25. What do you do for exercise? _____ How often? _____
26. Since you became pregnant have you used any over-the-counter medications? ❒ Yes ❒ No
    If yes, what? _____ How much? _____ How often? _____
27. Since you became pregnant have you used any prescription medications? ❒ Yes ❒ No
    If yes, what: _____ How much? _____ How often? _____
28. In your home, how do you store: ❒ Vitamins _____
    ❒ Medications _____ ❒ Cleaning agents _____
29. Do you have exposure to chemicals:
    a. At work? ❒ Yes ❒ No If yes, what? _____
    b. At home? ❒ Yes ❒ No If yes, what? _____
    c. With hobbies? ❒ Yes ❒ No If yes, what? _____

**PREGNANCY CARE**

30. Was this pregnancy planned? ❒ Yes ❒ No
31. How do you feel about being pregnant now? _____
32. Are you considering: Adoption? ❒ Yes ❒ No Abortion? ❒ Yes ❒ No
33. How does the father of the baby feel about this pregnancy? _____
    a. Your family? _____
    b. Your friends? _____

Name
Birth date
I.D. number
EDD

34. Do you have any of the following problems now? (Check all that apply.)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| a. Swelling of hands or feet | ❒ | ❒ | h. Heartburn | ❒ | ❒ |
| b. Constipation | ❒ | ❒ | i. Backache | ❒ | ❒ |
| c. Fatigue/sleeping problems | ❒ | ❒ | j. Vomiting | ❒ | ❒ |
| d. Vaginal discharge/bleeding | ❒ | ❒ | k. Nausea | ❒ | ❒ |
| e. Varicose veins | ❒ | ❒ | l. Headaches | ❒ | ❒ |
| f. Hemorrhoids | ❒ | ❒ | m. ❒ Other _____ | | |
| g. Leg cramps | ❒ | ❒ | _____ | | |

35. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive?
❒ Yes ❒ No ❒ N/A Please explain: _____

36. Do you have any traditional, cultural, or religious customs about pregnancy and childbirth you would like supported?
❒ Yes ❒ No Please explain: _____

37. Who gives you the most advice about your pregnancy? _____

38. What have you been told that you think is important? _____
_____

39. Do you use any natural or herbal remedies (example: ginseng, manzanilla, greta, magnesium, yerba buena)?
❒ Yes ❒ No If yes, what and how often: _____

40. Do you plan to have someone with you:
a. During labor? ❒ Yes ❒ No ❒ Do not know
b. When you first come home with the baby? ❒ Yes ❒ No ❒ Do not know

41. If you had a baby before, where was that baby(s) delivered?
❒ Hospital ❒ Clinic ❒ Home ❒ Other _____
Were there any problems? ❒ Yes ❒ No
If yes, please explain: _____

42. Have you had any losses in past pregnancies such as:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Miscarriages | ❒ | ❒ | Adoption | ❒ | ❒ | Abortion | ❒ | ❒ |
| Stillborn | ❒ | ❒ | SIDS | ❒ | ❒ | | | |

If yes, what/who helped you get through this? _____

43. If you have had other children, are they still living? ❒ Yes ❒ No ❒ N/A
If no, please explain: _____

44. Besides having a healthy baby, what are your goals for this pregnancy? _____

45. Do you plan to use a method of birth control after this pregnancy? ❒ Yes ❒ No ❒ Undecided
If yes, what method: ❒ Birth control pill ❒ Diaphragm ❒ Norplant ❒ IUD
❒ Foam and/or condoms ❒ Natural Family Planning ❒ Abstinence ❒ Sterilization ❒ Depoprovera

46. Have you ever had a sexually transmitted infection, such as gonorrhea, syphilis, chlamydia, herpes? ❒ Yes ❒ No
a. If yes, what and when: _____
b. Has your partner had a sexually transmitted infection? ❒ Yes ❒ No ❒ Do not know

47. Information given on HIV transmission, risk reduction behavior modification, methods to reduce the risk of perinatal transmission; counseling and referral to other HIV prevention and psychosocial services as needed; and referral for HIV testing. ❒ Yes ❒ No Initials: _____

Name
Birth date
I.D. number
EDD

## NUTRITION

48. Anthropometric data: (Complete the following.) Height _____ Current weight_____ Date_____
❒ Prepregnancy weight _____ ❒ Normal ❒ Underweight ❒ Overweight ❒ Very overweight
❒ Weight gain goal _____ ❒ Net weight gain _____ ❒ Adequate ❒ Inadequate ❒ Excessive
❒ Weight gain in previous pregnancies: lbs _____ ❒ Unknown ❒ N/A ❒ Weight grid plotted

49. Biochemical data: (Complete the following.)
❒ Blood: Date _____ Hgb/Hct _____ MCV_____ Glucose Screen _____
❒ Urine: Date _____ (Circle) Glucose + – Ketones + – Protein + –

50. Clinical data: (Indicate if any of the following apply.)
❒ Short pregnancy interval ❒ Anemia ❒ Diabetes: ❒ Prepregnancy ❒ Past pregnancy
❒ Serious infection ❒ Dental disease ❒ Hypertension: ❒ Prepregnancy ❒ Past pregnancy
❒ Hx low birth weight baby ❒ High parity (>4) ❒ Currently breastfeeding
❒ Age 17 years or less ❒ Digestive problems ❒ Hx intrauterine growth retardation
❒ Other medical/obstetrical problems: ❒ Past_____ ❒ Current_____

51. Do you take prenatal vitamins? ❒ Yes ❒ No Do you take iron? ❒ Yes ❒ No Other? ❒ Yes ❒ No

52. How would you describe your appetite? ❒ Good ❒ Fair ❒ Poor
Do you sometimes feel you can't stop eating? ❒ Yes ❒ No

53. Have your eating habits changed since you became pregnant? ❒ Yes ❒ No
If yes, please explain: _____

54. How many times per day do you usually eat? _____
Do you have questions or concerns about your weight and/or weight gain during pregnancy? ❒ Yes ❒ No
If yes, please list: _____

55. Have you had cravings for or eaten any of the following? (Circle all that apply.) ❒ Yes ❒ No
laundry starch freezer frost cornstarch clay paste plaster dirt other_____

56. Do you have any food allergies? ❒ Yes ❒ No If yes, please explain:_____
Are there any foods or beverages you avoid? ❒ Yes ❒ No If yes, please explain: _____

57. Are you on a special diet? ❒ Yes ❒ No
If yes, what kind? ❒ Weight loss ❒ Low salt ❒ Low fat/cholesterol ❒ Vegetarian ❒ Diabetic
❒ Other: _____

58. If vegetarian, do you eat: ❒ Milk and dairy products ❒ Fish/chicken ❒ Eggs

59. How many cups of the following do you drink in a day? _____ regular coffee _____ regular tea _____ sodas

60. Who usually does the following in your home? Buys food: _____ Prepares food: _____

61. Dietary intake: (check all that apply)

| | | | | | | |
|---|---|---|---|---|---|---|
| **LOW** | __ Vitamin A | __ Vitamin C | __ Other fruits and vegetables | __ Bread/grain/cereal | | |
| | __ Protein | __ All groups | __ Fluid | __ Milk | __ Iron | __ Fiber |
| **EXCESS** | __ Fat | __ Sugar | __ Salt | __ High Kcal. | | |

## INFANT FEEDING

62. If you have other children, did you breastfeed, or try to breastfeed them? ❒ Yes ❒ No ❒ N/A
Did you have trouble breastfeeding? ❒ Yes ❒ No How long did you breastfeed? _____

63. How are you planning to feed your new baby?
❒ Breast ❒ Formula ❒ Both breast and formula ❒ Other: _____ ❒ Do not know

## WIC REFERRAL

Provider signature _____ Date _____

Name
Birth date
I.D. number
EDD

**COPING SKILLS**

64. In the past month, how often have you felt that you could not control the important things in your life?
Have you felt that way: ❒ very often ❒ often ❒ sometimes ❒ rarely ❒ never

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

66. Are you currently having any of these problems: (Check all that apply.)

| | | Yes | No | | | Yes | No |
|---|---|---|---|---|---|---|---|
| a. | Financial difficulties | ❒ | ❒ | f. | Unemployment | ❒ | ❒ |
| b. | Housing problems | ❒ | ❒ | g. | Immigration | ❒ | ❒ |
| c. | Divorce/separation | ❒ | ❒ | h. | Legal | ❒ | ❒ |
| d. | Recent death | ❒ | ❒ | i. | Probation/parole | ❒ | ❒ |
| e. | Illness | ❒ | ❒ | j. | Child Protective Services | ❒ | ❒ |

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

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

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

70. Do you ever feel afraid or threatened by your partner? . . . . . ❒ Yes ❒ No
If yes, please explain: _____

71. Within the last year have you been hit, slapped, kicked, or physically hurt by someone? . . . . . ❒ Yes ❒ No
If yes, please explain: _____

72. Have you ever been a victim of violence and/or sexual abuse? . . . . . ❒ Yes ❒ No

73. Have your children ever been victims of violence and/or sexual abuse? . . . . . ❒ Yes ❒ No

74. Have your parents been victims of violence and/or sexual abuse? . . . . . ❒ Yes ❒ No

75. Do you ever get depressed? . . . . . ❒ Yes ❒ No

76. Have you ever felt so bad you planned or attempted suicide? . . . . . ❒ Yes ❒ No

77. Have you ever talked to a counselor? . . . . . ❒ Yes ❒ No
If yes, please explain: _____

78. Would you feel comfortable talking to a counselor if you had a problem? . . . . . ❒ Yes ❒ No

**TOBACCO, DRUG, AND ALCOHOL USE**

79. Do you smoke cigarettes? . . . . . ❒ Yes ❒ No
If yes, how many cigarettes per day? _____ for how many years? _____

80. Are you exposed to secondhand smoke at home or at work? . . . . . ❒ Yes ❒ No

81. Are you using chewing tobacco? . . . . . ❒ Yes ❒ No

82. If you smoke cigarettes or chew tobacco, have you:
❒ Considered quitting ❒ Set a definite date to quit ❒ Decided to cut down ❒ Decided not to quit at this time

83. How often do you drink alcohol (beer, wine, wine coolers, hard liquor, mixed drinks)?
❒ Daily ❒ Weekends ❒ 1–2 times per month ❒ Rarely or never

Name
Birth date
I.D. number
EDD

84. Have your alcohol habits changed since you got pregnant? ❒ Yes ❒ No
If yes how? _____

85. Are you interested in stopping or cutting down while you are pregnant? ❒ Yes ❒ No

86. Have you ever used street drugs (marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other)? ❒ Yes ❒ No
a. If yes, what: _____ How often? _____
b. Are you interested in quitting? ❒ Yes ❒ No

87. If your partner uses drugs or alcohol, does this create problems for you? ❒ Yes ❒ No

## EDUCATION AND LANGUAGE

88. Years of education completed: ❒ 0–8 years ❒ 9–11 years ❒ 12–16 years ❒ 16+ years
a. Are you currently enrolled in school? ❒ Yes ❒ No ❒ N/A
b. Will you return to school after the baby is born? ❒ Yes ❒ No ❒ N/A

89. What language do you prefer to speak: ❒ English ❒ Other _____

90. What language do you prefer to read: ❒ English ❒ Other _____

91. Which of the following best describes how you read:
❒ Like to read and read often ❒ Can read but do not read often ❒ Do not read

## EDUCATIONAL INTERESTS

92. Do you have experience with or have you received education in any of the following topics in the past (Column A—Do you know about?), or would like additional information during this pregnancy (Column B—Would you like more information?); both columns may be marked:

| TOPIC | COLUMN A Have Previous Experience/ Do You Know About? | COLUMN B Would You Like More Information? |
|---|---|---|
| How your baby grows (fetal development) | | |
| How your body changes during pregnancy | | |
| Healthy habits for a healthy baby | | |
| What you should eat while you are pregnant | | |
| Gaining weight in pregnancy | | |
| What happens during labor and delivery | | |
| What you need to know about preterm (premature) labor | | |
| Hospital tour | | |
| How to take care of yourself after the baby comes | | |
| Breastfeeding | | |
| Infant feeding | | |
| Circumcision | | |
| Helping your other children get ready for the new baby | | |
| Information about car seats/passenger safety | | |
| How to take care of your baby and keep it safe | | |

Name
Birth date
I.D. number
EDD

93. Will you have any difficulties (language/transportation) scheduling/attending classes? . . . . . ❒ Yes ❒ No

94. Will someone be able to attend classes with you? . . . . . ❒ Yes ❒ No
Who? _____

95. Is there anything special you would like to learn about? _____

96. How do you like to learn new things? (Check all that apply.)
❒ Read ❒ Talk one-on-one ❒ Group education ❒ Pictures and diagrams
❒ Watch a video ❒ Being shown how to do it ❒ Other _____

97. Do you have any mental, emotional, or physical conditions, such as learning disabilities, Attention Deficit Disorder, depression, hearing, or vision, that may affect the way you learn? . . . . . ❒ Yes ❒ No
If yes, please explain: _____

In developing a health education plan, also consider:

❒ Does the client have a medical problem or other risk factors related to pregnancy that requires education (i.e.: history of genetic disorder, diabetes, previous preterm labor, hypertension, etc.). This information may be located on the obstetric medical history form and/or question 50.

Assessment completed by:

_____ _____ _____
Name Date Minutes

_____
Title