County of San Bernardino

Comprehensive Perinatal Services Program

Perinatal Protocols

Name of CPSP Site

Address

Date

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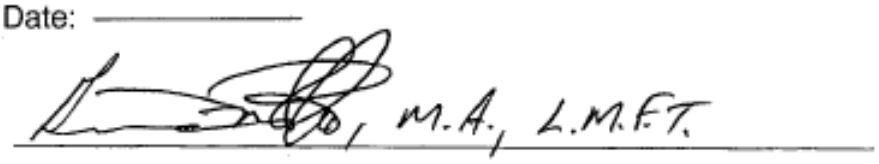
CPSP PROTOCOL SIGNATURE PAGE

CPSP Site

The undersigned have reviewed and approved the attached CPSP protocols:

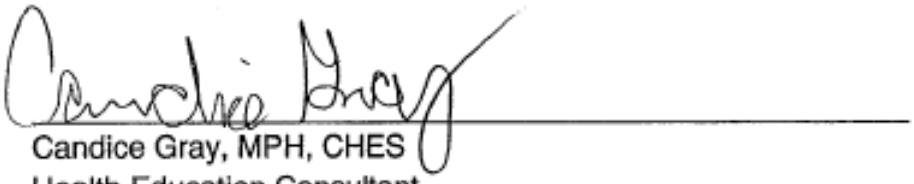
Name and credentials typed:
CPSP Provider (Physician or CNM)

Date: _____



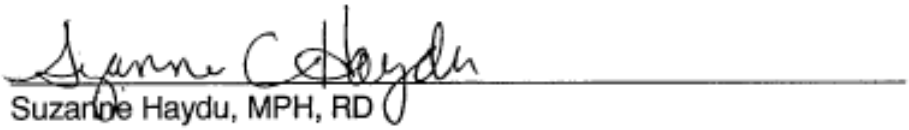
Gina M. Pinto, M.A., L.M.F.T.
Social Work Consultant

Date: 05/27/2014



Candice Gray, MPH, CHES
Health Education Consultant

Date: 6/5/14



Suzanne Haydu, MPH, RD
Nutrition Consultant

Date: 6-5-2014

STAFF ROSTER

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CPSP PROTOCOLS INTRODUCTION

These sample template protocols are based on the 2011 Alameda County Comprehensive Perinatal Services Program (CPSP) Perinatal Protocols and have been updated to use with the 2014 revised Three-column Integrated Initial and Trimester, and Postpartum Assessments and Care Plans. These protocols reference the 2014 *Comprehensive Perinatal Services Program Steps to Take (STT) Guidelines.*

Protocols are site-specific. Providers using these protocols must customize the protocols to their site by attaching an updated list of CPSP practitioner staff and choosing the appropriate words or inserting the appropriate resource in the areas that are in orange and signing the protocols on the signoff page. These protocols have already been signed off by State MCAH subject matter experts. Protocols are a staff resource and should be shared with and readily accessible for CPSP practitioners, including Comprehensive Perinatal Health Workers (CPHWs).

Providers may use other handouts for client information; if so, change the name of the handout in the Assessment forms as well as protocols and consult with your local Perinatal Services Coordinator. The handouts must include at least the same information as the recommended handouts and be of a suitable reading level.

For information on local resources, or for any questions, contact your local Perinatal Services Coordinator. A list of local Perinatal Services Coordinators is on the CPSP Web site at: *https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Local-Directory.aspx*

BILLING FLOW SHEET

Each time a client receives a CPSP service, the practitioner completing the service should complete the Billing Flow Sheet. This will enable the office to track the number of services each client has received and bill them accurately. The Billing Flow sheet is in the Appendix. Contact the Medi-Cal Fiscal Intermediary for billing questions.

CASE COORDINATION

The following staff will conduct CPSP Orientation, assessments, referrals, and case coordination. Insert names/titles of staff who will perform these functions. Whenever possible, clients will see the same staff member for orientation, assessment, and case coordination.

Case Coordination includes:

- Coordination and development of an Individualized Care Plan (ICP) for the client
- Modification of the care plan as needed
- Assisting the client with practical arrangements such as transportation, referrals and special appointments when necessary
- Verifying all of the client's documentation in the chart is complete, up-to-date and available to all team members
- Updating referral resources

Describe how staff will communicate regarding client needs. If the provider holds case conferences, insert frequency and time to conduct case conferences and describe who will attend case conferences

Describe process and frequency (annually, other) for updating referral resources]

State the resources and process that the office will use for translation (See STT for suggestions)

List referral resources in Appendix.

REQUIRED REFERRALS

WIC: Refer all clients and infants to WIC in the course of the Nutrition Assessment and document as indicated in the Assessment Form and Protocols. To make a WIC referral, fill out the WIC referral form completely with all information, and give it to the woman along with the address of the WIC office most convenient to her.
WIC referral forms are located on the WIC website at:
https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph247c.pdf
WIC referral form for postpartum/breastfeeding women:
https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph247b.pdf
WIC referral form for infant:
https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph247a.PDF
If the office does not have the medical information for the infant, provide the form to the mother and instruct her to take this to the pediatrician to complete.
Document WIC referral in the Initial Assessment, Nutrition Question 14, and in the Postpartum Assessment, Nutrition Question 9.

Genetic Screening: Referral for genetic screening is documented in the Provider's Progress Note and ACOG compliant form.

Dental Care: Referral for dental care is documented in the Health Education Assessment, Question 11.and in the Postpartum Assessment, Health education Question 7. Use the Perinatal Dental Referral Form.

Family Planning: Referral for Family Planning is documented in the Prenatal Health Education Assessment, Question 20, and in the Postpartum Assessment, Health Education Question 2

Well Child Care (CHDP): Information on CHDP and referral is documented in Prenatal Health Education Assessment Question 19 and Postpartum Health Education Question 9.

QUALITY ASSURANCE/QUALITY IMPROVEMENT

This office periodically reviews charts to assure that clients are receiving all appropriate services and that documentation supports services billed. State frequency and number of charts reviewed. State provider staff that conducts QA review. State members of the committee that will review results. The provider will use the QA tools on the MCAH Web site at https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/CQI-QA-Tools.aspx. The committee will meet to review results and develop a corrective action plan if needed. State frequency and time of meetings. Refer to the Provider Handbook, Pages 3-17-19 for more details.

CLIENT ORIENTATION PROTOCOL

Purpose:

- To inform the client about her pregnancy and postpartum care and available CPSP services
- To document the client's understanding that CPSP is voluntary and agreement to participate in CPSP services
- To review danger signs and symptoms

Procedure:

1. Provide initial Client Orientation to each new prenatal CPSP client at the time of the positive pregnancy test, at first obstetric visit or before the initial CPSP assessment. If the Client has transferred care from another CPSP provider, repeat the client orientation to inform the Client of practices at this site.
2. Provide additional orientation before any new procedure or referral.
3. Confidentiality is a critical component of the CPSP. In the partnership of her care, it is the health care team's responsibility to keep confidential the information that the woman provides. Her responsibility is to be truthful and honest in her answers. During the client orientation, limits of the client's confidentiality should be outlined such as mandatory reporting laws for child abuse, domestic violence, etc. Inform the client that other members of the

health care team will share the information among themselves, on a need to know basis, as needed to deliver the best care possible. Provide a copy of the office's HIPAA Privacy Practices to the client.

Practitioner: The following staff will conduct client orientation: (State which CPSP practitioners will conduct the orientation).

Documentation:

1. Follow medical charting standards and STT (Step to Take) *Documentation Guidelines*.
2. Document the initial client orientation on the pregnancy test counseling form, initial combined assessment form or progress note. Document subsequent orientation services in a progress note titled "CPSP Orientation." Each entry must include the name and title of the practitioner, date and minutes spent.
3. Record all orientation services on the CPSP Flow Sheet and Billing Summary (see appendix) indicating the number of units, date and initials of the person who provided the service.
4. Document the client's consent to participate in CPSP by checking the box in the Orientation area.
5. If the client declines to participate in any part of CPSP, make a note in the client's medical record that states the client's reason for declining a particular assessment or intervention.

Content:

1. Initial Client Orientation must be individual and face-to-face. At least one unit (minimum 8 minutes) must be provided.
2. At the initial Client Orientation, a CPSP practitioner will review with the client a copy of the STT handout, **Welcome to Pregnancy Care**, and will discuss the importance and content of postpartum care.
3. Check the box, **Client Orientation per Protocol** to document that you are following these procedures.
4. Explain that participation in CPSP is voluntary and check the box that states that client understands that CPSP is voluntary and agrees to participate.
5. Review the handout, STT HE **Pregnant? Steps for a Healthy Baby** at the orientation visit. Explain to the client that you will be reviewing information in more detail, but this handout is to enable her to know as early as possible what she can do to have the best outcome possible.
6. Throughout the pregnancy, an RN or the Provider will conduct additional orientation for procedures such as the Prenatal Screening Program, ultrasound, stress testing, amniocentesis, etc., as these issues arise. Will explain the procedures, who will do them, and why they are important. Reinforce any pre- or post-instructions.

7. In the second or third trimester, assure that the client receives a full orientation to the hospital where the client is expected to deliver. Describe the process and people responsible for providing hospital orientation information. This may include, hospital location, directions to the hospital, information on tours available, pre-admission information requested by the hospital and routine practices of the hospital.
8. Provide postpartum orientation to services and referrals; for example, lactation support services, on-going primary care for the Client.
9. Document all additional orientation after the initial orientation in the Billing Flow Sheet and in the Progress Notes. Include content, number of minutes, and staff name and CPSP title.
10. For additional information on Client Orientation see the *CPSP Provider Manual and the Steps to Take First Steps section.*

ORIENTATION STEP-BY-STEP INSTRUCTIONS

Client Orientation per Protocol

Check this box to document that staff conducted the orientation per the protocol. The CPSP practitioner staff member conducting the orientation should enter the actual number of minutes spent, legibly sign the assessment, and complete the billing flow sheet.

Client states understands "Welcome to Pregnancy Care"

Check this box to document that the client received and states she understands the **Welcome to Pregnancy Care or comparable** handout. Review each section with the client to make sure she understands pregnancy danger signs, her rights and responsibilities, CPSP services, how to access care, who will provide the care, how to make and cancel an appointment.

Understands CPSP is voluntary and agrees to participate

Check this box to document that the client agrees to participate in CPSP. Participation in CPSP is voluntary.

Reviewed STT HE **Pregnant, Steps for a Healthy Baby**

Check this box and review this handout with the client to help her know what to do early in pregnancy to have the best outcome possible.

Vitamins per Protocol

Check box to indicate that vitamins dispensed per protocol: Indicate protocol for dispensing vitamins: Dispensed 300 tablets; will bill and dispense 30/month; Dispensed 30 tablets with prescription for 30/month; provided prescription for vitamins, will fill at pharmacy

Document additional orientation in Progress Notes (i.e. childbirth education, hospital orientation, ultrasounds, other procedures).

Pregnancy Information

NOTE: The CPSP practitioner staff member who completes the first initial assessment, psychosocial, health education or nutrition, should review the client's medical record and record the following information:

DOB: Record the client's birth date.

Age: Record the client's current age.

If the client is a teen, follow STT *Teen Pregnancy and Parenting* Guidelines. Consult the *San Bernardino County Teen Resource Guide (see appendix) for* referrals to community programs for adolescents.

You are **not** required to ask the teen under 18 the age of the baby's father. However, if your teen client tells you the age of the father of her baby, consult with your supervisor or supervising physician and review the *When Mandated Reporters Must Report Sexual Activity by Minors in California* (see appendix) for guidance on whether or not you need to make a report to your local Children's Protective Services agency. Mandated reporters are responsible for assuring the report is completed and done in accordance with California State law and within specified time constraints. Follow *STT Teen Pregnancy and Parenting* and *Child Abuse and Neglect* Guidelines and submit the *Suspected Child Abuse Report* form (see appendix) to County Department of Social Services where the client resides. State how to document that a report has been made and indicate where copies of the report are kept in your office.

EDD (Estimated date of Delivery):

Record the client's estimated date of confinement, or delivery (abbreviated as EDC); if unknown, write "unknown". Enter this information later when the client's due date is known.

Wks. Gestation: Record the number of weeks gestation of the current pregnancy as stated in the medical record.

Grav: Record how many times the client has been pregnant. A multiple gestation counts as a single pregnancy

Para: Record the number of completed pregnancies beyond 20 weeks gestation, whether viable or nonviable. A multiple gestation counts as a single birth.

TAB: Record the number of (induced) therapeutic abortions.

SAB: Record the number of spontaneous abortions before 20 weeks.

INITIAL AND TRIMESTER ASSESSMENTS PROTOCOL

Purpose:

- To help the Client have a healthy baby by identifying her strengths, as well as problems and learning needs that affect the pregnancy during the first, second and third trimester of her pregnancy
- To develop an Individualized Care Plan to address those needs and build on those strengths

Procedure:

1. Conduct the initial assessment as soon as possible in the Client's prenatal care, ideally within 4 weeks of entry to care. Entry into care is defined as the first visit for any pregnancy-related reason (orientation or OB visit). If the woman enters prenatal care in the second or third trimester, start with the initial assessment and provide additional assessments as time permits or client need indicates. An initial combined assessment must last at least 90 minutes. If the assessments are done separately, each assessment must last at least 30 minutes.

2. Conduct a reassessment in the second and third trimesters. The 2nd Trimester Reassessment should be offered between 14 and 28 weeks and the 3rd trimester between 29 and 40 weeks.

   Review previous assessments and the woman's individualized care plan and provide documentation of follow up on unresolved issues. The client may also have new problems, issues or concerns.

   If the client is high risk and requires more frequent reassessments and interventions, use a progress note to record this service. Label the progress note "CPSP (and the type or types of intervention(s) provided to the client)" as appropriate, i.e., Psychosocial/Health Education/Nutrition. Legibly sign the progress note with your title, date and minutes spent.

3. A CPSP practitioner must complete the assessment during a face-to face contact with the client. It is not appropriate for a client to complete this form by herself.

4. Conduct the assessment in a conversational manner, and use language appropriate to the client's culture and education level, when asking about the topics included in the form.

5. Confidentiality is a critical component of the CPSP. In the partnership of her care, it is the health care team's responsibility to keep confidential the information that the woman provides. Her responsibility is to be truthful and honest in her answers. Limits of the client's confidentiality should be outlined, including mandatory reporting laws for child abuse,

domestic violence, etc. Inform the client that other members of the health care team will share the information among themselves, on a need to know basis, as needed so that they can deliver the best care possible. Refer to STT *Assessment Guidelines*, First Steps section for additional information on conducting the initial assessment.

6. At the completion of the assessment, summarize the needs that have been identified and assist the client in prioritizing them. Work with her to set reasonable goals and plans and document them on her Individualized Care Plan that corresponds to the assessment questions. Don't forget to go back and review and document follow ups on either the Individualized Care Plan itself or in the progress notes. If documenting follow up on a care plan item in the progress notes section, make a note on the ICP in the Comment column to refer to the progress notes for the date the follow up occurred. For example, "F/U, See progress notes dated XX/XX/XX."

7. Refer to the *office resource guide for* community referrals or call the *211* to obtain names of referral agencies.

Practitioner: The initial psychosocial, health education and nutrition assessments will be conducted when by practitioners at your location. The second and third trimester psychosocial, health education and nutrition assessments will be conducted when by practitioners at your location.

Documentation:

1. Follow medical charting standards and STT *Documentation Guidelines*.
2. Complete documentation for every question. If a question does not apply, indicate that by choosing or writing "N/A". If the client chooses not to answer a question, note: "client declines to answer." Do not ever leave a question blank or unaddressed.

3. Document the client's responses to the questions by checking the appropriate box in the left hand column.

4. In the Needs/Risks/Concerns column, write a brief explanation to each question that has colon (:) such as "No, describe:", "Relationship to Client:", "WIC, site:" or "self, type of work", etc.

5. Shaded responses indicate risks. Write the client's plan and interventions in the middle column. This is the client's Individualized Care Plan. The client's care plan is developed with the client. The second column has some suggested interventions such as: "Client will follow STT, HE ❑ **Prevent Gum Problems***",* "Client will avoid second-hand smoke", etc.

6. In the second column, write a brief explanation of each intervention that has colon **(:)** such as "Support person:", "Referred to:", "Has pediatric provider:", "Consult with obstetric (OB) provider re:" etc.

7. For a high risk client, a progress note may be used **in addition** to the assessment form. Label the progress note "CPSP Initial (and either, Psychosocial/Health Education/Nutrition or a combination of the realms covered, with appropriate minutes assigned to each realm) Assessment" as appropriate." Legibly sign the progress note with your title and date only. Record the total time spent completing the assessment on the assessment form in the space provided or in the progress note.

8. All notes and answers on the assessment should be legible, in English and include client response. Include the completed assessment in the client's medical record.

9. Use only those abbreviations your facility has approved.

10. The person completing the assessment and care plans must date and sign the document with at least their first initial, last name, and designated CPSP title. Signatures must be legible.

11. **CPSP services must be provided by or under the personal supervision of a physician.** California Code of Regulations, Title 22, Section 51179.5 **defines personal supervision** as "evaluation, in accordance with protocols, by a licensed physician, of services performed by others by direct communication, either in person or through electronic means." Effective for dates of service on or after June 1, 2012 each provider's protocols must define how personal supervision by a physician occurs and is documented. Please see number 5, CPSP Supervision Update, in the Medi-Cal Update Obstetrics/May 2012/Bulletin 455 at: http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/ob201205.asp#a5

12. **Comprehensive Perinatal Health Workers (CPHWs) must work under the direct supervision of a physician**, (Title 22, Section 51179.7(a)(10)(B). The protocols must define how direct supervision of CPHWs by a physician occurs and how this should be documented. Direct supervision may necessitate having on-site physician or a physician being offsite but "available" to immediately furnish assistance and direction if needed

13. Describe how personal and direct supervision occur here and state where in the chart the provider notes this has occurred. Describe how the provider documents **direct** supervision of CPSP care by CPHWs and **personal** supervision of CPSP care by other CPSP practitioners. If the initial assessment is completed by a CPHW (Comprehensive Perinatal Health Worker), it should be co-signed and dated by the physician directly supervising the CPHW or the MD must make a note in the chart stating that he/she has reviewed the assessment and concurs with the care plan, followed by his/her signature and the date of the review. Medical Assistants that are working as CPHWs must sign their CPHW title. Signatures must be legible. For other CPSP practitioners, the provider must make a note in the chart that he/she has reviewed the CPSP assessment and care plan.

14. Note time spent in minutes at the end of the assessment; indicate only time spent **face-to-face** with the client.

15. Record the assessment on the CPSP Flow Sheet and Billing Summary (see appendix) indicating the number of units, date and initials of the person who provided the service.

16. If the client does not want to participate in the initial assessment in one of more areas (psychosocial, health education or nutrition), make a note on the assessment that the client declined that area of assessment. No other support service assessments or interventions may be billed in an assessment area if an initial assessment has not been completed. Offer the initial assessment at a subsequent visit. The client may also decline to answer certain assessment questions. Make a note in indicating the client's response or refusal to answer a question. Never leave an assessment question blank. An assessment is complete when you have provided the client the opportunity to answer each question and documented the client's response or refusal to answer a particular question.

17. If a client has many issues, talk with the client to identify her highest priority issues and indicate the priority in the last column. Label highest priority issues 1, lesser priorities 2, 3, and so on, and address the highest priority issues as soon as possible. If an issue is low risk, you may indicate L in the third column (Comment) to document low risk.

18. In subsequent assessments, indicate the status of the issue in the third column and the date. R-Resolved F—Follow up. If there is a note in the Progress Note, enter P and date.

Content:

The 2014 *CPSP Integrated Initial and Trimester Assessments and Individualized Care Plan* contain all required elements for CPSP. If you wish to make any changes, contact your LHJ's Perinatal Services Coordinator.

Use this form to document the initial CPSP assessment and care plan as well as the second and third trimester reassessments and care plan or any additional assessments conducted due to high risk or client need. It may be used by one or more staff members over the course of the prenatal care. Staff may conduct the psychosocial, health education, and nutrition assessments in any order. The symbol [I] indicates that the question should be asked at the initial assessment. The symbols 2 and 3 indicate that the question should be asked in the second or third trimester.

The form has three columns; from left to right:

- Column 1 contains the assessment question and brief space to record the client's risks/concerns and responses. Shaded responses indicate higher risk.
- Column 2 is the client's individualized care plan where you indicate the client's plan, referrals given or Comprehensive Perinatal Services Program Steps to Take (STT) and other handouts reviewed with the client.

- Column 3 (Comment) allows you to prioritize the client's issues in the order of importance to the client or indicate if an area is low risk. Use L to indicate low risk (i.e., the client's response is not one of the shaded responses). Indicate the client's priorities for working on her issues, 1 being highest priority, 2, 3, and so on being lower priority. Indicate the status of an issue by indicating R for resolved or F for follow up and the date and practitioner initials in the right hand column. You may use progress notes if more space is needed to describe status; if so, enter "P" and the date so staff can find the applicable note.

These Protocols are generally organized in the following manner: 1) the question as it appears on the 2014 *Integrated Initial and Trimester Assessments and Individualized Care Plan* form, 2) instructions on how to record the client's answer, and 3) a reference to the appropriate section of the *STT Guidelines* (2014).

INITIAL AND TRIMESTER ASSESSMENT STEP-BY-STEP INSTRUCTIONS

PSYCHOSOCIAL INITIAL AND TRIMESTER ASSESSMENT

NOTE: Ask questions 1 through 13 during the initial assessment only. Ask questions 14 through 27 during the initial assessment **and** again each trimester.

1. **Is this a planned pregnancy?** If the client indicates this was not a planned pregnancy, check **No** and briefly describe e.g., "failed birth control" or "didn't think she could get pregnant." Also ask if this was due to her partner interfering with her birth control or forcing her to have unprotected sex. If so, inform the client that there are birth control methods her partner does not have to know about, notify the provider of the finding, and make a note to follow up in the third trimester and at the postpartum visit.

2. **Is this a wanted pregnancy?** Check **Yes** if client accepts the pregnancy and plans to continue prenatal care and raise the child. **If the client answers Yes, skip Question 3.** If the client indicates this is an unwanted pregnancy, check **No** and give a brief description of her answer. If the client indicates she is uncertain about her pregnancy provide the STT handout, **Uncertain about Pregnancy** and review this with the client.

3. **Are you considering abortion/adoption?** Check **No** if the client indicates she is not considering either. Check **Yes** if she is interested in either an abortion or adoption, and **circle the option**(s) she is considering. Provide the STT handout **Choices** if she is considering either. If she is before 20 weeks gestation, explore the issue of pregnancy termination following STT *Unwanted Pregnancy Guidelines* and providing the client with appropriate referrals. If she does not want to terminate her pregnancy, explore the client's

attitude towards adoption. Describe your discussion briefly, e.g., “will discuss TAB with medical provider” or “wants referrals to adoption agencies.” Make appropriate referrals.

Inform the client about the California’s safe surrender law. A parent, who is unable, or unwilling to care for their newborn, can safely surrender the baby within three days of birth. All that is required is that the baby be given to an on-duty employee of a hospital or safe surrender site such as designated fire stations. A confidentially coded ID bracelet will be put on the baby’s ankle and a matching bracelet offered to the surrendering person, to help connect the parent to the baby, should the parent want the baby back. For more information and to order free brochures for patients and posters: http://www.babysafe.ca.gov

4. **How does the Father of baby/Partner feel about the pregnancy?** Check the box (es) that describe how the client describes her partner’s feelings. Refer to STT *Emotional/Mental Health Concerns* Guidelines if needed. If the father is not involved, consider referral for legal advice to Legal Aid Society Of San Bernardino Inc. 909-889-7328 or 866-889-7328. If the client is a teen, refer to STT Teen “Pregnancy and Parenting--Father of the Baby” section, which describes the Paternity Opportunity Program. This is not only for teens. All unmarried parents will be asked if they wish to participate in the Paternity Opportunity Program. For more information refer to http://www.childsup.ca.gov/Resources/EstablishPaternity.aspx or 1-866-901-3212. If the client wishes more support, check the indicated box and write in the sources identified through discussion with her.

5. **What are your goals for this pregnancy?** Indicate what the client’s goals are for herself during this pregnancy. This is a subjective question; any response is acceptable. You can ask the question in a variety of ways, e.g., “What are your plans for yourself, after the baby is born?” or “Is there something you’re working on and want to achieve for yourself in the future?” Many women will answer that their goal is a healthy baby. With some prompting, they may mention career plans or other personal goals. This question can indicate the CPSP practitioner staff’s interest and concern in the Client as an individual, not just as a pregnant Client.

6. **Have you had issues with previous pregnancies?** Check **N/A** if this is client’s first pregnancy or **No** if the client’s previous pregnancy was normal.

   If she had problems in a previous pregnancy, check **Yes** and briefly describe e.g., “diabetes” or “preterm labor.”

   Would you like information on how to reduce risks in this pregnancy?, check the indicated box if the client states she wants to reduce risks in the pregnancy. Describe the risks she would like to reduce.

7. **Have you had a previous pregnancy loss or infant death?** Check **N/A** if this is the client’s first pregnancy or **No** if she did has not experienced any problems or losses. You may be able to answer this question based on the answer to Question 6. If **yes**, describe

briefly e.g., “stillbirth of son in 2009” or “three first trimester miscarriages.” If the client is expressing high anxiety, refer to STT *Emotional and Mental Health Concerns*. If the client is expressing unresolved grief, refer to STT *Perinatal Loss* and refer to local perinatal loss support group or other bereavement services and assure that the OB provider is aware of the history.

8. **Members of household (not including Client):**

   Number of adults:

   Relationship to Client:

   Indicate the number of adults in the household **not** including the Client and relationship to her e.g., “husband” or “parents-in-law.”

   Number of children:

   Relationship to Client:

   Indicate the number of children in the household and relationship to Client e.g., “8-month-old son, John” or “nieces and nephews.” Names of household members are optional.

   If the client indicates concerns, note them and explore with client ways to address the concerns. You may need to refer to additional housing or services for the people who live with her.

9. **Do all of your children live with you?** Check **N/A** if the Client has no living children or **Yes** if all of her children live with her. If any of her children do not live with her, check **No** and provide a short description of the circumstances, e.g., “3-year old son in foster care since birth due to mother’s drug use,” “12-year old daughter cared for by maternal grandmother in Guatemala since 2008 due to mother’s emigration” or “sons, ages 6 and 4, in custody of their father in Stockton since divorce in 2010.”

10. **Are you currently receiving services from local agency such as case management, home visiting, counseling, etc.?** Check **No**, if no services are being received**.** If services are being received, check Y**es**, and briefly describe e.g., “case management from [agency],” “client of Black Infant Health Program” or “drug treatment services from Second Chance.” If client is receiving services, ask her to sign a Release of information form, and fill in the contact information. This will allow you to coordinate her care with the other agency and fill in the contact information.

11. **Have you ever seen a counselor for personal or family issues or support? Check** No**, if she says “no.”** If she says “yes”, check **Yes** and briefly describe when and why e.g. “as a teen following rape; student health services 2008” or “currently seeing private therapist for depression.”

Do you need counseling now? If client states "yes", check **Yes** and refer to San Bernardino County Department of Behavioral Health – Outpatient Services http://www.sbcounty.gov/dbh/outpatientservices/outpatientservices.asp

or call 211 for information on local counseling resources. Note referral on the Care Plan. Otherwise check **No**.

12. **Have you ever been emotionally, physically or sexually abused by a partner or someone close to you?** If no, check **No.** If yes, check **Yes** and describe and indicate if the abuse occurred as a child or an adult e.g., "battered by former husband" or "molested as a child by uncle."

    If the client is under 18 years and is a victim or has been a victim of abuse in the past that has never been reported, a Mandated Report must be made and the date noted on the Assessment Form. Refer to STT *Child Abuse and Neglect Guidelines* section. If past abuse, refer to the section "When Past Abuse is Discovered." Insert process for obtaining and completing Suspected Child Abuse Report for Mandated Child Abuse Reporters Form SS8592 This form is available online at http://ag.ca.gov/childabuse/pdf/ss_8572.pdf and instructions are available online at this link: http://oag.ca.gov/sites/all/files/pdfs/childabuse/8572_instruct.pdf or, state where copies are available in the office and procedure to submit.

13. **Within the last year have you ever been hit, slapped, kicked, pushed, shoved, forced to have sex, forced to get pregnant or, or otherwise physically hurt by your partner or ex-partner:** if no, check No. If yes, check Yes and briefly describe the situation including the last time abuse occurred, how often this is a problem and have there been any injuries e.g., "hit by husband in the stomach last weekend; Client concerned about the baby" or "ex-boyfriend was abusive when he drank; no longer together." Follow STT *Spousal/Partner Abuse* Guidelines. To make a referral see San Bernardino Domestic Violence Resources at:

    http://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/San%20Bernardino.pdf

Do you have injuries now? If yes, notify the provider. The provider is required to complete an OCJP-920 Suspicious Injury Report, which is available at this link: *http://www.publichealth.lacounty.gov/mch/cpsp/forms/Suspicious%20Injury%20Report%20&%20Instructions.pdf* or state location of forms in the office and procedure for completing and submitting form.

> If the client states she is currently injured or you observe injuries, inform your supervisor immediately. The medical provider is responsible for appropriate evaluation, referral and mandatory reporting as needed. The medical provider may designate staff to make the report.

If the client is a minor, child abuse mandated reporting requirements apply. Refer to STT Teen Pregnancy and Parenting section and see the links in number 12 above.
Do you feel in danger now? If yes, review the **Cycle of Violence** STT handout, discuss need for safety plan, review STT handout **Safety when Preparing to Leave**, Refer to local resources. Note follow up in Question 14 in second and third trimester.

14. **Are you afraid of your partner or ex-partner?** If no, check No. If yes, check Yes and describe Client's fears and plans for safety. Follow STT *Spousal/Partner Abuse* Guidelines; review **Cycle of Violence**, **Safety when Preparing to Leave** STT handouts with client, refer to http://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/San%20Bernardino.pdf

Inform your supervisor and the medical provider immediately before the client leaves the office if the client is in immediate danger.

15. **Are you having any other personal or family challenges?** If no, check No. Check Yes if the Client has any difficulties that cause her concern, such as recent death, illness, separation, divorce, (un)employment, immigration, children with school problems, etc. Briefly describe, e.g., "mourning death of mother 3 months ago," or "child with severe learning disabilities." Follow STT Guidelines *Financial Concerns*, *Legal/Advocacy Concerns*, *New Immigrant*, and *Parenting Stress* as indicated. Refer to 211 for local resources, other resources in your area if available.

16. **Who do you turn to for emotional support?** Check all the people who help when the client has a problem, is feeling sad or needs advice. Indicate the name of the family member, friend or other support person. If she feels that she has no one to turn to, check "No one" and give a brief description, e.g., "here for 2 months from China; little social support." Refer to STT *Emotional/Mental Health Concerns or Parenting Stress* Guidelines. Refer to 211 for local support services, other resources in your area if available.

17. **Do you often feel down, sad or hopeless?** This is a question to screen for depression. If no, check No. If the Client answers yes to this question, check Yes and briefly describe her response e.g. "since her boyfriend left, she says she has been so sad that she forgets to eat" or "Client states she is sleeping 14 hours a day and doesn't have the energy to leave the apartment." Refer to STT *Depression* Guidelines. If yes, refer to provider or other qualified professional for further evaluation and appropriate intervention, including brief intervention and referral to insert referral resources.

    Do you often feel irritable, restless or anxious? This is a question to screen for anxiety. If no, check No. If the Client answers yes to this question, check Yes and briefly describe her response e.g. "Client says she always feels tense and cannot relax, even for a few minutes" or "she says that she is having a hard time concentrating at work and may be fired." Follow STT *Emotional or Mental Health Concerns* and refer to provider or other qualified professional for further evaluation and appropriate intervention, including brief intervention and referral to

insert referral resources in your area if available or http://www.sbcounty.gov/dbh/outpatientservices/outpatientservices.asp

Have you lost interest or pleasure in doing things you used to enjoy? This is a question to screen for depression. If no, check No. If the Client answers yes to this question, check Yes and briefly describe her response e.g. "she is so sad she stopped going to church each week which she has done all her life" or "she says that she used to like to play with her kids, but now it isn't any fun." Refer to STT *Depression* Guidelines, refer to provider or other qualified professional for further evaluation and appropriate intervention, including brief intervention and referral to insert referral resources or http://www.sbcounty.gov/dbh/outpatientservices/outpatientservices.asp

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18. **Did your parents use alcohol or drugs?** If no, check No. If yes, check Yes and describe the extent of use and any issues: e.g. "Parents drank every night, never seemed drunk", or "parents divorced when she was 2 because her father was an alcoholic" or "was placed in foster care at age 8 because of mother's cocaine addiction." Follow STT *Perinatal Substance Abuse* Guidelines. If yes, refer to provider or other qualified professional for further evaluation and appropriate intervention, including brief intervention and referral to insert referral resources or http://www.sbcounty.gov/dbh/outpatientservices/outpatientservices.asp

19. **Does your partner use alcohol or drugs?** Circle N/A if the Client does not have a partner, No if the partner does not use alcohol or drugs. If no, check No. If yes, check Yes and describe the extent of use and any issues, e.g. "partner is driving without a license since his DUI conviction" or "husband serving six months in county jail for drug sales."

20. **Before you knew you were pregnant, how much beer/wine/liquor did you drink?** If none, check None. If she consumed any alcohol, fill in the blanks with the **amount** and **type** of alcohol and circle the **frequency** (a day, week, and month) e.g. "was drinking 2 glasses wine per day" or "was drinking 4 beers per week."

    Are you drinking now? Ask about her current alcohol use since she found out she was pregnant. If no, check No. If yes, indicate her current use e.g., "now drinking 1 beer per week." If she has stopped drinking, circle None in the first column.

    Do you drink a lot at one time (4 or more drinks in about two hours)? If the Client is a current alcohol user, ask about binge drinking." If she does not binge drink, circle No in the first column. If she does binge drink, indicate her response with amount, type and frequency e.g. "4 beers 3 times a month"

    If the Client drinks any alcohol, refer to provider or other qualified professional for further evaluation and appropriate intervention, including brief intervention and referral to insert

referral resources or
http://sanbernardino.networkofcare.org/mh/services/subcategory.aspx?tax=RX-8450.6600

Provide brief education about the risks to the baby and assist her in making a plan to quit. Follow STT *Drug and Alcohol Use and Perinatal Substance Abuse Guidelines.* Provide the STT handout, **Your Baby Can't Say No**. Discuss the client's confidence in quitting and note it on the care plan. Identify with the client a support person that can help her.

Follow up on this issue at future assessments.

If the client is not interested in cutting down on her drinking or is binge drinking, refer to the medical provider for additional evaluation, Client education and referral to appropriate resources.

21. **Before you knew you were pregnant, how much tobacco did you smoke (including e-cigarettes)?** If none, check NONE. If she smoked any tobacco products, check **Was Smoking** and state amount, type (cigarettes, pipe, chewing tobacco, etc) and how often e.g. "was smoking 20 cigarettes a day."

    Are you smoking now? If no, check No. If yes, check Yes and describe the Client's current tobacco use. If she has cut down, indicate the number of and type she now smokes per day.

    If the client smokes, provide brief education about the risks to the baby and assist her in making a plan to quit. Provide the STT handout, **You Can Quit Smoking**. Refer to California Smokers' Helpline http://www.californiasmokershelpline.org/index.htm **,** the *Comprehensive Tobacco Treatment Program (CTT) (see appendix) or to other programs listed in the San Bernardino Resources for Smokers that are ready to quick:*

    http://wellness.ucr.edu/Cessation%20Resource%20List%20San%20Bernadino%20updated%20%20April%202012.pdf

    Indicate your interventions as appropriate. Follow up at subsequent assessments.

If the client is not interested in cutting down on her smoking, refer to the medical provider for additional evaluation, Client education and referral to appropriate resources.

22. **Do people smoke around you?** If no, check No. If yes, indicate the number of hours a day she is exposed to smoke. Follow STT *Secondhand Tobacco Smoke* Guidelines *and review the handout. Follow up at subsequent assessments.*

23. **Before you knew you were pregnant, how much did you usually use marijuana or other drugs?** Other drugs may include cocaine, crack, PCP, methamphetamines, heroin, prescription painkillers or sedatives, etc. Fill in the blanks with the amount and type of drugs and circle the frequency (per day, week, or month) e.g. “was using 2 bowls of pot a day” or “was using meth twice a month.”

    Are you using drugs now? If no, check No. If yes**,** check **Yes** and ask about her current drug use since she found out she was pregnant. Fill in the blanks with the amount and type of drugs and circle the frequency (a day, week, month) e.g. “2 bowls of weed a week” or “meth 3 times a day.” If the Client uses any drugs, provide brief education about the risks to the baby and assist her in making a plan to quit. Refer to the provider for referral to local resources: http://sanbernardino.networkofcare.org/mh/services/subcategory.aspx?tax=RX-8450.6600

    Follow STT *Perinatal Substance Abuse* Guidelines. Help her identify a support person to help her quit.

    In subsequent assessments: Ask the client if she is using any drugs now. If she has stopped using any drugs, check None. If she is using drugs, note the **type** and **amount** and reinforce risks. Make a note about her level of confidence in quitting. Refer to provider for brief intervention, referral for treatment. Obtain information to share information with other providers. If client referred, follow up at subsequent visits to ensure that client enters care.

If the client is using any drugs, refer to the medical provide and/or licensed personnel for additional evaluation, client education and referral to appropriate resources.

24. **What is your source of financial support?** Check all that apply and give a brief description e.g., “housekeeper 3 days a week” or “housepainter.” Ask if there are any concerns and note them; e.g., “laid off 2 months ago; receiving unemployment benefits.” Note the client’s plan if there are concerns.
    If the client has financial or legal concerns, follow STT *Financial Concerns* and *Legal/Advocacy Concerns* Guidelines and make appropriate referrals to community resources or call 211 for available resources.

25. **Where do you live?** Check the appropriate box and describe if “other” such as “homeless shelter” or “car.” Ask if there are any concerns and note them; e.g., “landlord refuses to fix mold problem” or “received eviction notice last week.”

    If the client has housing concerns, follow STT Financial Concerns and Legal/Advocacy Concerns Guidelines and make appropriate referrals to community resources, emergency shelters, etc. or call 211 for available housing resources.

If the Client is homeless and you are unable to find emergency shelter, inform your supervisor immediately before the client leaves the office. The medical provider or other licensed practitioner is responsible for appropriate evaluation and referrals.

26. **Any other questions or concerns?** Briefly describe any other psychosocial (social, emotional or financial) problem identified by the Client or yourself and indicate interventions.

27. **List the client's main psychosocial strengths.** Discuss the assessment with the client and note the client's stated strengths.

Psychosocial minutes spent: Note time spent in minutes at the end of the initial assessment and each trimester reassessment. A legible signature, title and date are also required.

If the initial assessment is completed by a CPHW (Comprehensive Perinatal Health Worker) including MA's (Medical Assistants), an MD must document direct supervision by signing the assessment or noting in the progress note. Co-signatures are **not** required for the trimester reassessments.

HEALTH EDUCATION INITIAL AND TRIMESTER ASSESSMENT

NOTE: Ask Questions 1 through 9 during the initial assessment only. Questions 10 through 14, 24 and 25 are asked during the initial assessment **and** again each trimester. Questions 15 through 23 are asked during the third trimester only.

1. **How do you like to learn?** Ask how she likes to learn about new topics. If she is slow to respond, prompt her by reading off the options on the form, and check all that apply. Tailor your health education services to her preferred learning style such as using more videos if she prefers those. Note the type of materials you will use and refer to Text 4 Baby.

   How well do you write/read? Check the box that describes the client's statement of how well she reads. To check her comprehension, ask her to silently read a handout, such as **Pregnant? Steps for a Healthy Baby,** and ask her to share with you something new or interesting she learned from the pamphlet. If it is not clear that she was able to read or actually understand the pamphlet, follow the STT *Low Literacy Guidelines*.

2. **Do you have someone you can talk to about what we discuss today?** If no, encourage her to involve a support person by sharing educational materials after her appointments. If yes, note the person's name.

3. **What language do you prefer to speak?** State the client's preferred speaking language.
   What language do you prefer to read? State the client's preferred reading language.
   If the Client speaks or reads another language, follow STT Guidelines *Cross-Cultural Communication, No Language in Common with Staff* and *Using Interpreters*.
   In what language would you like materials? Provide materials to her in her preferred language, when available

4. **What was the last grade you completed?** Indicate the last grade completed in school. This may give a general idea of her literacy level. You may want to ask where she attended school (which country). If the client is a teen who needs support, refer to the Cal-Learn, or other local program to support her continuing her education. If the client is an adult who has not completed high school, refer to local GED program if client is interested.

5. **How long have you lived in this area?** If she has lived in the area less than a year, she may need more information about local services.

   Do you plan to stay in this area for the rest of your pregnancy? If no, note where she intends to go and when, and provide a copy of her medical records if she needs to leave the area. Help her to find a provider before moving.

   Do you know how to get other health care services? If she answers No, ask her if she has specific questions or concerns you can help her with and note in space provided.

6. **Do you have any physical difficulties that affect learning (such as vision, hearing, learning disabilities)?** Tell the Client that you ask all clients about these so that you can provide appropriate services. Ask if any of these affect her ability to learn.

   If her disability, such as vision, has been adequately corrected so that it doesn't interfere with her learning, you don't need to check "Yes."

   If she answers "Yes", describe the disability in the area provided and discuss with her ways she can be accommodated to benefit from the health education services. Ask what has helped her in the past. Consult with provider or health education consultant to identify accommodations.

7. **Who gives you advice about your pregnancy?** Check all that apply. Write in any others that are not on the list under "other." If woman is African American, refer to Black Infant Health Program (BIH).

   What are the most important things they have told you? Briefly describe the advice she has been given e.g., "don't eat spicy foods" or "get plenty of sleep." Reinforce helpful advice. If she is following advice that may be harmful to the pregnancy, such as "when you're pregnant you can eat for two" or "smoke marijuana to relieve nausea", make a note of it here and coordinate care with the medical provider.

8. **Are you exposed to any of the following at work or home?** Check the specific dangers the Client may be exposed to and indicate your interventions in the third column. Provide and review listed STT handouts.

If the Client may be exposed to dangers, coordinate care with the medical provider who will evaluate the risk to the Client.

9. **We ask all clients this question: do you have any of these risk factors for diseases like chlamydia, gonorrhea, herpes, or HIV?** Ask the client about the items listed. If the client answers yes to any, review the handouts listed with the client and refer her to the provider for diagnosis and treatment.

10. **Which of the following topics would you like to learn about?** Provide health education for the client regarding any of these topics in which she is interested. Check "No" if she is not interested in learning and follow up in future visits to assess her knowledge and offer information. Refer to the OB provider if she has questions about medical topics.

11. **Have you had a dental check-up in the past 12 months?** If no, indicate the last time she had dental care. Fill out a *Prenatal Dental Referral Prescription* for medical provider to sign and make a dental referral so she will receive care during the pregnancy. Refer to STT Health Education *Oral Health during Pregnancy* Guidelines. Refer to local list of dentists who take Medi-Cal. Provide assistance in obtaining appointment if needed.

Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? If yes, briefly describe problems. Fill out a *Prenatal Dental Referral Prescription* (see appendix) for medical provider to sign and make a dental referral. Refer to STT Health Education *Oral Health during Pregnancy* Guidelines. Refer to local list of dentists who take Medi-Cal

Follow up at subsequent visits.

12. **How will you come for appointments?** Ask if there are any transportation issues. Refer to local resources for transportation, if needed.

13. **Do you know how to use a seat belt when pregnant?** Encourage the client to wear a seat belt every time she rides in a vehicle. If she doesn't know how to wear one during pregnancy, check "No" and inform the client of the correct way to wear the seat belt:

    - Always wear both the lap and shoulder belt.
    - Buckle the lap strap under your belly and over your hips.
    - Never place the lap belt across your belly.
    - Rest the shoulder belt between your breasts and off to the side of your belly.
    - Never place the shoulder belt under your arm.
    - If possible, adjust the shoulder belt height to fit you correctly.
    - Make sure the seat belt fits snugly.

Review the information in the STT HE handout, P**regnant? Steps for a Healthy Baby**

Then, ask the client to describe to you how she would put on a seat belt.
Follow up at subsequent visits.

14. **Can you describe what you think might be pregnancy danger signs, preterm labor, labor induction, and when to call the doctor for prenatal concerns?** Ask the client to describe these to you and note any gaps. Provide basic health education on needed topics. Pregnancy danger signs are in the handout, **Welcome to Pregnancy Care.** Preterm labor information is in the handout, **If Labor Starts too Early.** Information on labor induction is in the STT section on *Labor Induction* and the STT handout **What You Need to Know about Labor Induction.** Reinforce that it's best to remain pregnant for at least 39 weeks unless there is a medical indication otherwise. Make sure the Client knows what number to call during business hours and the evenings/weekend. *Insert number to call*
Follow up at subsequent visits.

If the Client has specific concerns about her pregnancy, coordinate care with the medical provider who will give the Client instructions based on her medical history and

Note: Ask Questions 15- 23 in third trimester

15. **What are your plans for labor and delivery?** Ask each of the questions about the Client's plans for labor and delivery. Check "No" if she does not have plans in a particular area. Review STT My Birth Plan with client. *Insert numbers for hospital tours and childbirth preparation classes.* If the client does not have a support person, notify the hospital or birthing center, refer to local resources, if any.

16. **Do you have any questions about how to take care of yourself after delivery?** Inform the client that the staff where she has the baby will teach her how to take care of herself after delivery.

Discuss the importance of returning to the office for postpartum care and the procedure for making appointments.

17. **Do you know about infant care, safety, illness, safe sleep, immunizations?** Check the items she knows about. Review basic information on infant care and document interventions in the second column as needed.

18. **Do you have the following items?** Ask each of the questions about the Client's preparations for the baby. Check "No" if she has not made plans for the newborn's basic needs and childcare (if needed). Refer to local resources; if any call 211.

19. **Have you chosen a doctor for the baby?** Check "Yes" if the client has chosen a pediatric provider for her newborn and indicate the name of the provider in the first column. If not, make a referral and indicate the name(s) of the provider(s).Inform the client of the services

covered by CHDP. Patient handouts in multiple languages available at this Web site: http://www.dhcs.ca.gov/services/chdp/Pages/InfoBrochure.aspx Refer to list of CHDP providers.

20. **Do you plan to have more children?** If **yes,** discuss with client her plans for more children after the birth of this baby.

    How many? Ask how many children she wants and enter the number.

    How far apart? Ask how far apart she wants them to be. Advise that it is best to have children at least 24-36 months apart, and to consult with the obstetric provider if planning to get pregnant again before this baby is 18 months old.

    What birth control methods are you interested in? Note these, and make sure the client is aware of Long Acting Reversible Contraceptive methods (IUDs, implants). Use Family PACT materials and materials in Steps to Take to review contraceptive methods. Encourage the client to discuss these with her provider

    Do you have any concerns about your ability to use birth control? If she expresses concerns about remembering to use birth control or failure of methods, inform her that long acting reversible contraceptives address both of these concerns. If she expresses concern that her partner interferes with her birth control, inform the client that there are methods her partner does not have to know about. Encourage the client to discuss these with her provider.

21. **Do you go to a doctor for regular medical checkups?** Note the name of her primary care provider. If she does not have a source of primary care, make a referral to a primary care provider so she will have access to preventative health care.

22. **Do you have health insurance for your health care after your pregnancy?** Find out if the Client will continue to have insurance coverage after her postpartum Medi-Cal eligibility ends. If she will no longer be covered, refer her to your TAD or local resources and, Covered California, or call 211.

23. **Has your doctor told you that you have any health problems that need follow up after your pregnancy (diabetes, hypertension, obesity, depression etc.)?** Review the medical problem list to identify any medical problems. Discuss with the client any need for medical care for ongoing health problems after the postpartum period. Encourage her to see her primary care provider to help with specialist referrals for her chronic conditions. Encourage the Client to control any chronic health care problems before she becomes pregnant again.

24. **Do you have any other questions or concerns?** Ask the Client if she has another issue that you have not covered. If yes, describe and indicate your interventions.

25. **List the client's stated main educational strengths.** Review the assessment at least each trimester with the client and note her strengths; use these to help address her needs. Add to this list as the pregnancy progresses.

Health Education minutes spent: Time spent in minutes must be noted at the end of the initial assessment and each trimester reassessment. A legible signature, title and date are also required.

If the initial assessment is completed by a CPHW (Comprehensive Perinatal Health Worker) it should be co-signed by a physician on the assessment form or the provider must note in the chart that they have reviewed and approved. Co-signatures are **not** required for the trimester reassessments. State how the provider documents **direct** supervision of CPSP care by CPHWs and **personal** supervision of CPSP care by other CPSP practitioners. Insert the process for personal and direct supervision here and state where in the chart the provider notes this.

NUTRITION INITIAL AND TRIMESTER ASSESSMENT

NOTE: Question 1 is asked only at the initial assessment. Questions 2-19 are asked at the initial assessment **and** again at each trimester reassessment. Weigh the client at every visit and plot her weight on the appropriate grid.

Anthropometric: Height, Weight and Body Mass Index (BMI)

1. **Pre-pregnancy Weight and Height, Weight Category and Weight Gain Grid Used:**

   If available, use the woman's medical record for a pre-pregnancy weight near the time of her last menstrual period. Most women will not change an entire BMI (body mass index) category (Underweight, Normal, Overweight, and Obese) in the first trimester. So if she is in her first trimester and doesn't know her pre-pregnant weight, use her weight at the current visit. For this, you would plot the first weight on the 0 line and monitor her rate of gain in the following visits. If the woman is past 16 weeks gestation and her weight is unknown, refer to the health care provider for a preferred method to estimate pre-pregnant weight. Use the pre-pregnancy weight along with her height to determine her BMI and which weight gain chart to use. Select the weight gain grid based on the client's BMI category. If the client is carrying twins, use the Twin weight gain grids. Review the weight gain recommendations for her weight category with the client. Weigh the client at every visit and plot her weight on the grid.

   State when to refer to a Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN) or provider

2. **Current Weight Gain:** Weigh the client; plot the weight on the weight gain grid;, look to see if the weight gain is in the appropriate area. Ask her how she feels about her weight gain or loss so far. Ask if she has any questions. If the weight gain line is outside the normal area, discuss with the provider. If the weight gain is too low, provide and review STT Tips to Gain

Alert the medical provider in the situations outlined in the "Referral" section of the STT *Weight Gain During Pregnancy* Guidelines.

Weight. If the weight gain plotting is above the normal weight gain recommended, provide and review STT Tips to Slow Weight Gain.

Refer to a health care provider and RD/RDN for in-depth assessment if:

- Underweight: Prepregnancy BMI<18.5
- Obese: Prepregnancy BMI ≥30
- 1st Trimester: Excessive weight loss
    a. If underweight, more than 4 pounds loss in the first 12 weeks of pregnancy
    b. If normal weight or overweight, more than 5 pounds loss in the first12 weeks of pregnancy
    c. If obese, more than 8 pounds loss in the first 12 weeks of pregnancy
- 2nd or 3rd Trimester: Excessive or inadequate weight gain
    a. weight gain is more than 6.5 pounds in any month or weight gain remains above the recommended range (normal weight, overweight, or obese)
    b. At 24 weeks, weight gain is less than
        i. 14 pounds at 24 weeks if underweight
        ii. 12 pounds at 24 weeks if normal weight
    c. At 26 weeks, weight gain is less than 8 pounds, if overweight
    d. No weight gained by:
        i. 16 weeks if underweight or normal weight
        ii. 20 weeks if overweight or obese
    e. Gain of less than
        i. 3 pounds in any single month if underweight
        ii. 2 pounds in any single month if normal weight or overweight
        iii. 1 pound in any single month if obese

Follow up on weight at each visit and plot it on the weight gain grid.

State additional issues that require referral to an RD/RDN or provider

Biochemical: Lab Tests

3, Abnormal lab values

Hemoglobin, Hematocrit, Glucose screen: Note these values, indicate abnormal lab values.

Anemia is diagnosed when:
Hemoglobin (Hgb) 1st & 3rd trimester <11g/L
Hemoglobin 2nd trimester < 10.5g/L
Hematocrit (Hct) 1st & 3rd trimester <33 vol%

Hematocrit (Hct) 2nd trimester <32 vol%

If low hemoglobin or hematocrit, discuss with provider, provide and review STT Nut **Get the Iron You Need,** and, if the provider has prescribed iron pills, provide and review STT Nut **If You Need Iron Pills.** Note any changes to lab values at subsequent assessments. Note if the Mean Corpuscular Volume or MCV is out of normal range:

(first trimester) <85 μm^3 or >97.8 μm^3
(second trimester) <85.8 or >99.4 μm^3
(third trimester) <82.4 or >100.4 μm^3

Discuss with health care provider if values out of this range and whether the provider recommends treating for folic acid deficiency anemia. If so, provide and review the STT Nut **Get the Folic Acid You Need.**

Note if client is diagnosed with Gestational Diabetes Mellitus (GDM) based on 75 Gram, 2-HR Oral Glucose Tolerance Test Diagnostic blood glucose values:

Fasting: ≥ 92 mg/dL
One hour: ≥ 180 mg/dL
Two hour: ≥ 153 mg/dL
One abnormal value is diagnostic of GDM.

State when to refer to an RD/RDN or provider. Document education and client's goal/plan for gestational diabetes in Question 6 in Nutrition care plan.

Clinical

4. **Blood Pressure (BP):** Document BP at every visit. Notify provider if BP is over 120/80 and address any nutrition recommendations the provider recommends, such as, slow weight gain.

5. **Do you have any of the following possibly nutrition-related discomforts?** If yes, note any current discomforts that the client is experiencing and inform the provider of the client's symptoms.

   Do any of these discomforts keep you from eating as you normally would? If no, check No. If yes, check Yes and describe the frequency and severity of the discomforts e.g., "vomiting three times a day." Discuss symptoms with the provider and on approval, provide and review STT Nut **Nausea and Vomiting, Heartburn**, and **Constipation** Guidelines as needed, and document review with client. Refer to the medical provider and a RD/RDN if the client has severe nausea and vomiting unresponsive to routine management causing dehydration, metabolic disturbance and weight loss.

   Follow up at subsequent assessments.

Alert the medical provider in the situations outlined in the "Referral" section of the *Nausea and Vomiting, Heartburn,* and *Constipation Steps to Take* Guidelines.

6. **Do you have any of these nutrition-related health issues?** If no, check No. If yes, check Yes and notify the provider and provide interventions as instructed. Refer to an RD/RDN or provider if

    a. 15 years or less at time of conception or less than 3 years since onset of menses
    b. Short interpregnancy interval (Less than two years between delivery or termination of previous pregnancy and current conception)
    c. Breastfeeding while pregnant
    d. Has had gastric surgery
    e. Any Diabetes
    f. Previous poor birth outcomes:
        i. Low birth weight infant (<5.5 lbs)
        ii. Small-for-gestational-age (SGA) infant
        iii. High birth weight infant (>9 lbs)
        iv. Congenital anomaly
        v. Hemorrhage (antepartum)
    g. Ever had an eating disorder
    h. Other: such as, high parity (5 or more previous deliveries at greater than 20 weeks gestation), multiple gestation, severe infection/chronic disease or physical signs of malnutrition.

    State additional issues when to refer to an RD/RDN or provider

Clients who have diabetes with the following risk factors _____ will be referred to _____ for medical

7. **Are you currently taking any of the following?** If no, check No. If yes, check Yes and note the items the client is taking, provide and review the STT guidelines as indicated. State when to refer to an RD/RDN or provider

8. **Have you had any changes in your appetite or eating habits since becoming pregnant?** If no, check No. If yes, check Yes and note any changes, provide and review STT handouts as indicated, State when to refer to an RD/RDN or provider.

9. **Do you limit or avoid any food or food groups (such as meat or dairy)?** If no, check No. If yes, check Yes and note any foods the client avoids.

    Why do you avoid these foods? Note the client's answer. e.g., "vegetarian; eats eggs and dairy" or "doesn't like milk; gives her a stomach ache." Follow STT *Lactose Intolerance* if she says she has trouble digesting milk products. Provide and review handouts with the client as needed.

If the client avoids foods that are high in calcium, protein, Vitamin B12, folic acid, or iron discuss other sources. Provide and review STT handouts indicated in the assessment form. State when to refer to an RD/RDN or provider.

Alert the medical provider in the situations outlined in the "Referral" section of the STT *Vegetarian Eating* Guidelines.

Follow up at subsequent assessments, note any changes, and provide information and referral to an RD/RDN as indicated.

10. **Have you fasted during this pregnancy or do you plan to fast?** If no, check No. If yes, check Yes and describe and refer to provider or RD/RDN or provider.

11. **Do you eat any of the following? raw or undercooked eggs/seafood/meat, deli meats or hot dogs, soft cheeses, unpasteurized milk, cheese or juice, bean sprouts, shark, swordfish, king mackerel, tilefish, tuna > 6 ounces/week?** If no, check No. If yes, check Yes and describe type, source and frequency e.g. "likes to eat raw fish" "likes her eggs really runny." **Fish > 2x/week? Locally caught fish >1x/wk.?** If so, note type, source and frequency. Provide and review STT handouts regarding safe foods. Check the California state Office of Environmental Health Hazard Assessment OEHHA's website http://www.oehha.ca.gov/fish.html to get up-to-date advisories on chemicals found in fish caught in local waterways.

Alert the medical provider if client needs further evaluation and advice on food

Follow up at subsequent assessments. State when to refer to an RD/RDN or provider.

12. **Do you eat or have you craved any of the following? Clay, dirt, ice, freezer frost, plaster or plaster chips, laundry starch, cornstarch** If no, check No. If yes, check Yes and note type of craving, the frequency and amount e.g., "eats a tray of ice cubes a day." Review STT *Pica* Guidelines if needed. State when to refer to an RD/RDN or provider.

Alert the medical provider if client does not agree to avoid unsafe non-food items.

13. **Do you have the following:** oven, stove, electricity, refrigerator, microwave, clean running water. If no, describe how client prepares and stores food. Provide and review listed STT handouts as indicated. **Follow up at subsequent assessments. Refer to local housing assistance.**
State when to refer to an RD/RDN or provider.

14. **In the past month, were you worried your food would run out before you or your family had money to buy more? Were there times when the food did not last and you did not have money to get more?** If no, check No. If yes to either of these questions,

check Yes and describe how frequently this happens e.g., “Food stamps run out every month and family eats at church kitchen” or “parents skip dinner 2 times a week so the children can eat.” Provide and review to STT Nut **You Can Stretch Your Dollars**. Provide and review STT handouts listed and *Financial Concerns Guidelines* if she has food access problems.

Do you use any of the following food resources? Discuss WIC**;** make a referral to WIC, CalFresh, local emergency food sources. Indicate the WIC site where she is receiving services. If no, indicate the reason and make a referral, evaluate ongoing engagement and participation in WIC at each visit; if the Client declines a WIC referral, make a brief note; continue to suggest participation in WIC to client at every visit. **Follow up at subsequent assessments.**
State when to refer to an RD/RDN or provider.

15. **What kind of physical activity do you do? How often? How long?** Note type and frequency of activity e.g., “walks her dog every day about 6 blocks.” If Client is a heavy exerciser such as running 5 miles daily, provide and review STT Health Education **Stay Active When You Are Pregnant** with client for guidance.

On an average day, are you physically active at least 30 minutes each day? On an average day, do you spend over 2 hours watching a screen (TV, computer)? Discuss that people who watch a screen for more than 2 hours are less active and have more difficulty controlling their weight.

Has a doctor told you to limit your activity? If yes, refer her to the provider to discuss activity. Note responses.

If Client does not engage in physical activity at least 30 minutes each day, describe Client’s reasons e.g., “too tired after working all day.” If the doctor has not told her to limit her activity, encourage her to identify easy ways to be active at least 30 minutes per day (does not have to be consecutive 30 minutes) and provide and review the STT handouts listed. Indicate interventions in the “Physical activity” section of the Nutrition Individualized Care Plan. State when to refer to an RD/RDN or provider.

16. **Complete one of these nutrition assessments: 24-hour Perinatal Dietary Recall, Perinatal Food Group Recall, or other approved Food Frequency Questionnaire**
Indicate which assessment the provider office uses.

Follow the instructions in the Steps to Take manual. Review STT handouts listed as indicated. State when to refer the client to an RD/RDN or provider.

Breastfeeding

17. **First trimester: What have you heard about breastfeeding?** Note her response.

What do you think about breastfeeding your new baby? Check the client's response. Encourage the client to think about breastfeeding, provide and review STT Nut **Nutrition and Breastfeeding, Common Questions and Answers** to **address any questions she has.**

Do you know the risks of not breastfeeding? If no, provide and review the STT NUT, **Formula vs. Breast milk.**

Is there anything that would prevent you from breastfeeding? If yes, note the client's response. For example, "mother-in-law says breastfeeding hurts too much" or "partner says he would be jealous of the baby." Address concerns. Provide education on risks of not breastfeeding, techniques, and available assistance.

Have you ever breastfed or pumped breastmilk for your baby? Note the client's response If no, enter why not. If yes, how long. Address any concerns.

What was your previous breastfeeding goal? Note the client's response. If the client was not able to breastfeed as long as she wanted, assure her that help is available to enable her to breastfeed longer. Refer to lactation expert, such as an IBCLC, if needed.

What is your current breastfeeding plan? Describe the client's plan. Provide and review STT NUT **My Action Plan for Breastfeeding**

If you are going to breastfeed, who can you go to for breastfeeding help? Note the client's resources. Provide and review the handout, STT NUT **My Breastfeeding Resources,** Write in local breastfeeding resources; WIC, IBCLC, provider staff.

Provide and review appropriate listed STT handouts with the client to address her concerns and encourage her to breastfeed her new baby.

Second trimester: Ask: What do you think about breastfeeding your new baby? Note the client's response. **What are your new questions about feeding your new baby?** Note the questions and answer the questions, provide and review handouts, **refer to local breastfeeding resources (if you are not aware of local breastfeeding resources ask the Perinatal Services Coordinator)**

Third trimester: Ask: How do you plan to feed your infant in the first month of life? Note all that apply. Review STT NUT **My Birth Plan, A Guide to Breastfeeding, Breastfeeding Checklist for My Baby and Me,** and **My Breastfeeding Resources** so that client is prepared to breastfeed in the hospital.

What are your new questions about feeding your baby? Continue to provide encouragement and resources so that the client can plan to breastfeed. Encourage her to use WIC resources. If client has questions about returning to work or school while

breastfeeding, provide and review **Breastfeeding and Returning to Work or School.** Refer to local breastfeeding resources

State when to refer to an RD/RDN OR PROVIDER and other local breastfeeding resources.

18. **Other nutrition risk/dietary issue:** Ask the Client if she has another nutrition issue that you have not covered. Describe and indicate your interventions.
19. **List the client's stated main nutrition strengths.** Identify these with the client. Help the client acknowledge her strengths and build on these to address her needs.

Nutrition minutes spent: Note the time spent in minutes at the end of the initial assessment and each trimester reassessment. A legible signature, title and date are also required.

If the initial assessment is completed by a CPHW (Comprehensive Perinatal Health Worker) including MA's (Medical Assistants), it should be co-signed by a physician on the assessment form or the provider must note in the chart that they have reviewed and approve. Co-signatures are **not** required for the trimester reassessments. State how the provider documents **direct** supervision of CPSP care by CPHWs and **personal** supervision of CPSP care by other CPSP practitioners.

POSTPARTUM ASSESSMENT PROTOCOL

Purpose:

- To assess the client's post-partum strengths and needs in relation to infant care and parenting skills and her personal health
- To develop an individualized care plan to build on her strengths and address identified needs
- To promote Interconception Health

Procedure:

1. If possible, begin the CPSP postpartum assessment one week after delivery. Encourage the client to come in to the office within one week of delivery to provide breastfeeding support, and assess mental status and any immediate postpartum needs. If the client is unable to come in, call the client if possible to assess her status and offer assistance.
2. Complete the CPSP postpartum assessment in person within ____ weeks after delivery. Encourage the client to come in for additional support services as indicated by the postpartum assessment.

3. You may provide services until the end of the Client's Medi-Cal eligibility (at the end of the second month following the month of delivery). Use a progress note to record this service. Label the progress note "CPSP (Psychosocial/Health Education/Nutrition)" Sign the progress note with your title, date and minutes spent.

4. Review previous assessments and individualized care plans to provide follow up of unresolved issues. The Client may have also new problems, issues or concerns.

5. The form is to be completed in a face to face interview by the CPSP practitioner and never by the Client herself.

6. One or more staff members may complete the sections of the Postpartum Assessment in any order.

7. At the completion of the assessment, summarize the client's strengths, the needs that have been identified and assist the client in prioritizing them. Work with her to set reasonable goals and document them on her Individualized Care Plan in the second column. Indicate priority and status of issues in the third column.

Practitioner: The psychosocial, health education and nutrition postpartum assessment will be conducted by practitioners at your location.

Documentation:

1. Follow STT *Documentation* Guidelines.

2. Record the postpartum assessment on the CPSP Flow Sheet and Billing Summary indicating the number of units, date and initials of the person who provided the service.

3. If the client does not want to participate in the postpartum assessment, make a note at the end of the form stating that the Client declines the service.

Content:

The *CPSP Postpartum Assessment and Individualized Care Plan* contain all of the required elements for CPSP. If you wish to make any changes, notify your local Perinatal Services Coordinator and discuss these with him/her.

This form is used to document the CPSP postpartum assessment. It may be used by one or more staff members and completed on the same day, or multiple dates.

The form has three columns:

- Column 1 is the assessment.

- Column 2 is the Client's individualized care plan where you indicate actions taken, referrals given or STT and other handouts reviewed with the Client.

- Column 3 allows you to indicate the priority of an issue and to indicate the status or resolution of an issue. Place a 1, 2, 3, and so on to indicate the client's priorities for addressing her needs, with 1 being highest priority. Indicate status (i.e. follow up dates, resolution dates, your initials and the date in the third column.

These Protocols are generally organized in the following manner: 1) the question as it appears on the *CPSP Postpartum Assessment and Individualized Care Plan* (2014) form; 2) instructions on how to record the Client's answer 3) reference to the appropriate section of the *Comprehensive Perinatal Services Program Steps to Take (STT) Guidelines* (2013).

If possible, review the delivery record and Client discharge summary for relevant information prior to conducting the postpartum assessment. Also, review previous assessments and individualized care plans to provide follow up of unresolved issues.

POSTPARTUM ASSESSMENT STEP-BY-STEP INSTRUCTIONS

Baby

1. **Baby's DOB:** Record the date of the baby's birth.
2. **Name:** Record the baby's name. Check male or female.
3. **Weight at birth:** Record the baby's birthweight and circle either pounds or grams.
4. **Length at birth:** Record the baby's length at birth and circle either inches or centimeters.
5. **Weeks gestation:** Record the length of the pregnancy in weeks.
6. **Type of Delivery: Vaginal or Cesarean**
7. **Multiple births:** If yes, give the name, sex and birthweight of the other babies. Follow STT Health Education *Multiple Births-Twins and Triplets* Guidelines.

PSYCHOSOCIAL

1. **Did you have any issues with delivery?** If no, check **NO**. If yes, check **YES** and briefly describe e.g., "Emergency C-section," "excessive blood lost" or "stillbirth of 3200 gram male" and indicate interventions. Follow STT Psychosocial *Pregnancy Loss* Guidelines and handouts if needed. If there was an infant loss, follow STT, *Perinatal Loss,* and review the handouts, **STT PSY, Loss of your Baby, and Ways to Remember Your Baby.**
2. **Does the baby have any medical issues?** If no, check **NO**. If yes, check **YES** and briefly describe e.g., "baby born at 29 weeks and will need to spend 4-6 weeks in the NICU" or "baby

born with cleft palate that will need surgical repair." Follow STT Psychosocial *Birth Defects* Guidelines if needed.

3. **What are you enjoying most about your new baby?** Note the client's response.

   What is most challenging? Briefly describe e.g., "Client says that she gets angry when the baby cries" or "Client says that the baby doesn't love her". Follow STT Psychosocial Guidelines *Parenting Stress, Emotional/Mental Health Concerns,* and *Depression* if needed. Discuss how to soothe the baby if indicated, and refer to the Social Worker or Provider for additional screening to rule out perinatal mood disorder concerns and for appropriate referrals.

4. **Are family members adjusting to the baby?** If yes, check **YES**. If no, check **NO** and briefly describe e.g., "Client's 2-year old wants to nurse like the new baby" or "husband doesn't want the baby sleeping in their room."

5. **Are you getting the support you need from your family or partner?** If yes, check yes. If no, check No and briefly describe e.g., "Husband laid off from his job last week," "Client's mother has been diagnosed with liver cancer" or "Father of the baby still denies paternity." Follow the appropriate STT Psychosocial Guidelines.

6. **Have you had any emotional concerns that need follow up?** If no, check **NO**. If yes, check **YES** and note the client's response. Even if she says no, continue to the next questions.

   Over the past two weeks, have you felt down, depressed or hopeless? If no, check **NO**. If yes, check **YES** and briefly describe e.g., "Client says she feels like she is a bad mother".

   Have you had little interest or pleasure in doing things? If no, check **NO**. If yes, check **YES** and briefly describe, for example, "Client says she just doesn't enjoy anything anymore"

   For the past month, more days than not, have you felt anxious, nervous, worried, irritable, or overwhelmed? If no, check **NO**. If yes, check **YES** and note the client's response and its effect on her: "Client says she hasn't slept for the last 36 hours because of her fear that the baby may die"

   If you added up all of the time you have slept, how many hours would you say you have been able to sleep per day in the past two days? Check the number of hours the client reports sleeping for the last 24 hours in the space provided, e.g. less than 4 hours, 4-6 hours." If the client says she has slept less than 4 hours, also ask her how many days in a row she has slept less than 4 hours. If she says she has had less than 4 hours of sleep for more than two days in a row, refer her to the Social Worker or Provider for additional screening to rule out perinatal mood disorder concerns and for appropriate referrals. Review STT "Depression" section and follow "Steps to Take" suggestions.

For each of the above questions, refer to STT Psychosocial *Emotional and Mental Health Concerns and Depression* Guidelines and handouts. If client responds yes to any of these depression screening questions, refer to the provider or other qualified personnel for further evaluation and referral. Insert referral resources. http://www.sbcounty.gov/dbh/outpatientservices/outpatientservices.asp

Consult with your supervisor immediately before the client leaves the office if the Client may be a danger to herself or others. The medical provider is responsible for appropriate evaluation, referral and mandatory reporting as needed.

If there is a referral, insert follow up mechanism to assure that client obtains service.

7. **Do you drink alcohol?** If no, check No. If yes, check yes **and** note type, amount and frequency. If excessive, refer to provider for counseling. If breastfeeding, advise not to breastfeed or pump for baby's consumption within 3 hours of drinking alcohol or at all if trying to become pregnant.

8. **Do you use any drugs other than prescribed?** If no, check No. If yes**,** notify provider and advise to delay another pregnancy until drug free.

9. **Do you smoke or do people smoke around you or the baby (including e-cigarettes)?** If no, check No. If yes, advise not to allow smoking around the baby and to quit for her health. Refer to smoking cessation if client is willing.

10. **Within the past year, has your partner hit, slapped, kicked, choked, forced you to have sex, or otherwise physically or emotionally hurt you?** If no, check no. If yes, check Yes, refer to STT guidelines, provide handouts **Cycle of Violence, Safety when preparing to leave**, notify provider, refer to local domestic violence resources. http://www.sbcountyda.org/HelpingVictims/DomesticViolenceShelters.aspx. If there are current injuries, provider must complete a Domestic Violence Injury Report (see prenatal protocols). If client is a minor, mandated child abuse reporting requirements apply (see prenatal protocols). Note the date of mandated reporting and whether it is for Domestic Violence (DV) or Child Abuse (CA)

11. **What are your plans for the future?** Note whether client plans to go back to work, go to school, or stay at home and timeline. Briefly describe e.g., "Client wants to return to community college next semester" or "Client needs job". Refer to employment agency or education/training. Advise of rights for private space for breastfeeding or expressing milk at work.

12. **Do you need help finding childcare?** If no, check No. If yes, check Yes and briefly describe: e.g. client needs child care for job/school If yes, Refer to local resources or 211

13. **Do you need essential baby supplies?** If no, check No. If yes, check Yes and briefly describe e.g., “baby needs a crib” or "runs out of diapers each week.” Refer to local resources or 211

14. **Do you have any other social, emotional or financial concerns?** If no, check No. If yes, check yes and briefly describe any other psychosocial (social, emotional or financial) problem not listed above e.g., “ Utilities will be cut off next week”, “ Having problems with her mother-in-law about how to feed the baby,” or “Angry at her husband about not helping out more with the older children.” Refer to the appropriate STT Guidelines if needed.

15. **Review the assessment with the client and identify strengths.** Note the strengths and use these to address her needs.

HEALTH EDUCATION:

1. **Do you have any questions about body changes, postpartum discomforts, or self-care after pregnancy?** Ask about each of the listed areas and provide health education to the Client regarding any questions or concerns she has about body changes following pregnancy e.g., “losing weight so she can fit into her regular clothes.” For medical questions, refer her to the OB provider.

   Are you receiving Text4Baby? If yes, check Yes. If no, check No and refer her to Text 4Baby. She can access Text4Baby by texting Baby (for English) or Bebé (for Spanish) to 511411. Reinforce that Text4Baby provides a great deal of useful information during the year after the baby is born.

2. **How many children are you planning to have?** Note the number

   How far apart? Note the spacing—follow the interventions in the assessment form

   Are you using birth control? If yes, note type. If no, ask, why not, encourage her to use birth control if she does not want to conceive, and to consult with her provider if planning to conceive less than 18 months after the birth of this child. Help her to make a family planning appointment if not using contraception and unable to provide a method at this appointment.

   What methods of birth control are you interested in? Inform the client of long acting reversible contraceptive methods (LARCs) and emergency birth control and encourage her to discuss this with her provider.

   Do you have any concerns about your ability to use birth control? If she states that she is concerned that she could forget or that the method could fail, inform her that long acting reversible contraceptives can alleviate these concerns. If she states that her partner does not support her use of birth control, inform her that there are methods the partner does not have to know about and notify the provider of her concerns.

   Encourage the client to keep her family planning appointment. Advise her to wait 18 months, take folic acid and avoid chemical exposure before conceiving again.

3. **Are you exposed to chemicals or toxins at home or elsewhere?** Encourage the client to avoid toxic substances.
4. **Do you have health insurance for your own health care in the future**? Find out if the Client will continue to have insurance coverage after the postpartum Medi-Cal eligibility ends. Medi-Cal eligibility ends at the **end** of the second month **following** the month of delivery. For example, if she delivers her baby in October, she will have Medi-Cal until the end of December. If the client is not undocumented, refer her to Covered California to obtain coverage.

   If she will no longer be covered by Medi-Cal and your site participates in the County Medically Indigent Services Program (CMSP), refer her to a financial eligibility worker to enroll. If your clinic does not offer CMSP services, refer her local resources for inexpensive care. http://www.cmspcounties.org/.
5. **Do you have a doctor for regular medical checkups?** If she does not have a primary care provider, make a referral to _____ or suggest she call the local resources or her health plan if she has coverage.
6. **Has a doctor told you that you have any health issues that need follow up?** Discuss with the client if she will need medical care for ongoing health problems such as diabetes, hypertension, obesity, depression, etc. that will require further care after the postpartum period. Encourage her to see her primary care provider to help with specialist referrals for her chronic conditions. Encourage her to have these under control before she conceives again.
7. **Did you see a dentist during pregnancy?** If not refer to local dentist/clinic that takes Medi-Cal
8. **Do you have any sore/bleeding gums, sensitive/loose teeth, bad taste or smell in the mouth?** If yes, refer to local dentist or clinic that takes Medi-Cal. Review STT HE **Prevent Gum Problems, See a Dentist, Keep Teeth Healthy**
9. **Do you have a doctor and appointment for the baby?** List the baby's pediatric provider or indicate referral given. List date of appointment if available. Refer to _____ provider if no current provider.
10. **Do you have any questions about newborn care?** Ask about each of the boxes, check the ones about which she has questions. Provide basic information on infant care. Use the STT *Infant Safety and Health Guidelines* Encourage the mother to make a list of questions for the baby's pediatric provider.

    Safety: Ask about each of the checked items; encourage her to make these items inaccessible to babies and toddlers. Use the STT *Infant Safety and Health Guidelines*. Verify that client has a car seat.

Safe sleep free publications can be ordered at

https://www.nichd.nih.gov/publications/Pages/pubs_details.aspx?pubs_id=5805

11. **Do you have a dentist for the baby?** If not, encourage her to identify a dentist and discuss the need for baby to see a dentist before first birthday or first tooth, discuss prevention of caries and oral care, and provide referral to local dentist or clinic that takes Medi-Cal. Follow indicated STT resources.

12. **Do you have any other questions or needs?** Provide client education and answer her questions regarding other perinatal topics; if needed, consult the medical provider or other staff member.

Health Education minutes spent: Time spent in minutes must be noted at the end of postpartum health education questions. A legible signature, title and date are also required.

NUTRITION:

1. **Client's total weight gain, weight at this visit, desired weight, Desired BMI range.** Measure client's current height and weight. Calculate BMI using weight and BMI chart in Steps to Take. Record the Client's total weight gain during pregnancy and today's weight. Help the Client make reasonable goals to reach a healthy postpartum weight. Encourage regular physical activity such as walking. If breastfeeding, review STT NUTR **My Plate for Moms/My Nutrition Plan for Moms** with the Client, otherwise use the WIC **Be a Healthy Mom** handout. *State when to consult with a Registered Dietitian (RD/RDN or provider)*

2. **Lab values:** Note any abnormal lab values, discuss with provider and review STT handouts as indicated. *State when to consult with RD/RDN or provider*

3. **Clinical: Are there any nutrition-related health issues?** If any nutrition related health issues, discuss with provider, State when to refer to an RD/RDN and/or other health care provider, such as for an eating disorder.

Dietary

4. **Which of the following are you taking? C**heck the items the client is taking, discuss findings with provider, review listed STT handouts, as indicated.

   State when to consult with RD/RDN or provider.

5. **Are you on a special diet, including reducing or eating extra calories?** If no, check No. If yes, describe.

   Do you limit or avoid any food or food groups, such as meat or dairy? If no, check No. If yes, describe.

Why do you avoid these foods? Note the client's reason.

If the client is a vegetarian review the handout on vegetarian diets

If the client avoids food groups, review STT NUTR **Choose Healthy Foods**. If the client eats little fiber, provide and review STT NUTR **Constipation: What you can Do**, and if low in enriched grains, provide and review STT NUTR **Get the Folic Acid You Need.** If the client avoids milk, provide and review STT NUTR **Foods Rich in Calcium** and **Do you have Trouble with Milk Foods**.

If the client avoids animal products, provide and review STT NUTR **Vitamin B12 is Important**

State when to refer to an RD/RDN or provider.

6. **How is infant feeding going overall?** This is an open-ended question so let the client respond in their own words. All clients should receive education on breastfeeding and other infant feeding options. Follow STT *Breastfeeding Guidelines* and indicate interventions and any referrals (lactation expert, registered dietician, primary care provider for infant or woman). Discuss this at the visit in the first week postpartum. As needed, review materials in *Tips for Addressing Breastfeeding Concerns* and *What to Expect while Breastfeeding: Birth to Six Weeks.*

   How many times in 24 hours, day and night do you feed your baby? Fill in the number of time per day the client reports giving each item to her baby. Note breastfed babies usually do not need any other food or drink before 6 months of age. Encourage her to breastfeed exclusively for 6 months; begin to add solid foods at 6 months while continuing breastfeeding as long as she and the baby wish to.

   Does your baby ever go more than three hours between feedings? If the baby goes more than three hours without feeding, the client may need to wake the baby up every three hours to feed to make sure the baby gets enough nourishment. **Refer to in-house or local lactation specialists such as IBCLCs for support.**

   Number wet diapers/day: Provide and review STT NUTR **A Guide to Breastfeeding** referring to *How to Know your Baby is Getting Plenty of Milk* and STT NUTR **Breastfeeding Checklist for My Baby and Me**

   Number dirty diapers/day: Provide and review STT NUTR **A Guide to Breastfeeding** referring to *How to Know your Baby is Getting Plenty of Milk* and STT NUTR **Breastfeeding Checklist for My Baby and Me.**

Refer to her provider if baby is having fewer than the number of wet or dirty diapers for the appropriate number of days postpartum indicated in the handout.

Using pacifier? Discourage use of a pacifier before breastfeeding is well established.

Does baby take a supplement with Vitamin D? If exclusively breastfeeding or consuming less than 1 quart of infant formula a day and not taking Vitamin D, refer to provider for Vitamin D supplement.

Are you planning to return to work or school? If yes, provide and review STT NUTR **Breastfeeding and Returning to Work or School.**

If breastfeeding, are you having any of these concerns? Ask about each box and check if she is having any concerns. If cracked, sore nipples; **refer to provider or lactation specialist.** If not enough milk, provide and review STT NUTR ***A Guide to Breastfeeding*** referring to *Will I have enough milk to feed my baby?* For breastfeeding concerns**, refer to in-house or local lactation specialists such as IBCLCs for support. State when and who to refer for lactation support.**

What breastfeeding questions can we answer today? Provide and review STT NUTR **Nutrition and Breastfeeding, Common Questions and Answers** and STT NUTR **My Breastfeeding Resources** if the client has any concerns.

7. **Have you fasted while breastfeeding or do you plan to fast while breastfeeding?** If yes, describe why. If for religious reasons, encourage her to discuss this with her spiritual advisor as most religious traditions may excuse breastfeeding women from fasting if this is detrimental to her or the baby. Inform her that dehydration can decrease her milk supply. Refer to an RD/RDN or IBCLC for further discussion.

8. **Do you have the following?** Ask about each of the items and check the ones the client does not have. Review STT handouts listed as indicated. **State when to consult with RD/RDN or provider.**

9. **In the past month, were you worried whether your food would run out before you or your family had money to buy more?**

   In the past month, were there times when the food that you or your family bought just did not last and you did not have money to get more?

   Have you used any of the following food resources?

   Have you used any other food resources, such as food banks, pantries, or soup kitchen?

   If yes to any of these questions, review the listed handouts with the client. Refer her to WIC, CalFresh, local emergency food resources or 211.
   State when to consult with RD/RDN or provider.

10. **What kinds of physical activity do you do?** Note type, how often, how long.

On an average day, are you physically active at least 30 minutes per day? If yes, check yes. If no, check no and encourage her to be physically active at least 30 minutes per day to maintain physical fitness and help weight control.

On an average day, do you spend over 2 hours watching TV or other screen? If no, check no. If yes, check yes and inform client that spending over two hours a day watching a screen can lead to being overweight.

Has a doctor told you to limit your activity? If yes, refer her to the provider to discuss activity.

If the doctor has not told her to limit her activity, encourage her to be physically active at least 30 minute per day and limit screen time. If Client does not engage in physical activity at least 30 minutes each day, describe Client's reasons e.g., "too tired after being up all night." If the doctor has not told her to limit her activity, encourage her to identify easy ways to be active at least 30 minutes per day (does not have to be consecutive 30 minutes). Indicate interventions in the "Physical Activity" section of the Nutrition Individualized Care Plan. State when to refer to an RD/RDN or provider.

11. **Complete the 24-hour Perinatal Dietary Recall or Perinatal Food Group Recall, or approved Food Frequency form.** Use **My Nutrition Plan for Moms** when counseling. Follow the instructions in the Steps to Take Manual for conducting these assessments. If the client is not eating sufficient foods, or is eating the wrong foods, review the appropriate handouts from those listed.
    State when to consult with RD/RDN or provider.
12. **Other risk or dietary issue? Document and refer, as appropriate.**
13. **Review assessment with client and identify strengths: Build on these strengths as you develop the care plan with the client.**

Nutrition minutes spent: Time spent in minutes must be noted at the end of postpartum nutrition questions. A legible signature, title and date are also required

PERINATAL HEALTH EDUCATION CLASS PROTOCOL

Purpose:

- to provide perinatal health education in a group setting.
- to provide an opportunity for Clients to learn from each other and discuss pregnancy-related issues.

Procedure:

1. Perinatal education classes may be offered in addition to individual CPSP assessments.

2. Clients may be referred to classes based on their health education needs and interests.
3. Client's support person may be encouraged to attend the class with the Client.
4. At the beginning of each class, Clients must sign-in (see appendix for sample sign-in sheet).
5. At the end of each class, note the "minutes spent" for each Client beside their name on the sign-in sheet.

Practitioner: The perinatal education classes will be conducted by practitioners at your location.

Documentation:

1. Follow STT *Documentation* Guidelines.
2. Two or more CPSP clients make up a class; the Client's support person, such as a *partner, may attend a class, but is not billable as a member of the group.*
3. *Perinatal education classes should be documented both:*
    - On a Client sign in sheet that also includes the name and date of the class and the signature and title of the CPSP practitioner conducting the class (to be kept on file), and
    - In each Client's chart including the name, date and length of the class in minutes and the signature and title CPSP practitioner conducting the class. These items will be documented in a progress note or perinatal class form.
4. *Class outlines describing the content of each perinatal education class must be kept on file.*
5. *All perinatal education classes should also be recorded on the CPSP Flow Sheet and Billing Summary (see appendix) indicating the number of units, date and initials of the person who provided the service.*
6. *Only face-to-face class time is billable.*

Content:

Attach Perinatal Health Education Class Lesson Plans

May use lesson plans included in the appendix

San Bernardino County

Comprehensive Perinatal Services Program

APPENDICES

- CPSP flow sheet and billing summary
- Welcome to Prenatal Care (English/Spanish) – Ask your Perinatal Services Coordinator
- Comprehensive Tobacco Treatment Program (English/Spanish)
- Mandated report of consensual disparate age sexual intercourse to child abuse authorities
- Mother to be California fax referral form
- Perinatal Dental Referral form
- WIC referrals: prenatal, postpartum and pediatric
- Suspected Child Abuse Referral form
- Suspicious Injury Report
- Online resources search - 211
- Teen Resource Guide - Ask your Perinatal Services Coordinator -PSC)

CPSP support services are billed per 15 minute units.

0-7 minutes = 0 units and is not billable
8-22 minutes = 1 unit
23-37 minutes = 2 units
38-52 minutes = 3 units
53-67 minutes = 4 units
68-82 minutes= 5 units
83-97 minutes= 6 units

CPSP Flow Sheet and Billing Summary

CPSP Case Coordinator: _____

Client Orientation (unit=15 minutes)

Z6400	Individual client orientation (may be billed throughout care–antepartum and postpartum)								

Obstetrical Visits (unit=1 visit)

Z1032 -ZL	Initial comprehensive pregnancy-related medical visit less than or equal to 16 wks gestation	

or

Z1032	Initial comprehensive pregnancy-related medical visit more than 16 weeks gestation	

Z1034	Antepartum medical visits (2^{nd} visit through the 9^{th} visit)									
Z1036	10^{th} antepartum visit									
Z1038	Postpartum medical visit									

Prenatal Vitamins (unit=300 day supply)

S0197	Prenatal vitamins dispensed (30 day supply -10 units)										

Initial Support Services Assessments and Care Plan Development (unit=15 minutes)

Note: bill only after all 3 support service assessments have been completed

Z6500	Nutrition, health education, and psychosocial assessments all completed within 4 weeks of initial medical visit or any one of the 3 initial assessments, whichever is provided first; **minimum 30 minutes each assessment**		
	Nutrition assessment (bill additional time in Z6202)		
	Psychosocial assessment (bill additional time in Z6302)		
	Health education assessment (bill additional time in Z6402)		

Nutrition Services (unit=15 minutes)

Z6200	Initial nutrition assessment and care plan development only if Z6500 not billed; first 30 minutes (bill additional time in Z6202)								
Z6202	Initial nutrition assessment each subsequent 15 minutes over 30 minutes								
Z6204	Follow-up nutrition–individual (reassessments and interventions) (billable only after initial nutrition assessment)								
Z6206	Follow-up nutrition–group (CPSP Prenatal only)								
Z6208	Postpartum nutrition assessment								

CTT - Comprehensive Tobacco Treatment Program (Spanish Flyer available)

Comprehensive Tobacco Treatment Program

Are you Pregnant & SMOKING?

- Just QUIT Smoking?
- Want to stay Quit?

WE CAN HELP!!

Earn while you learn:

FREE

- *Diapers*
- *Xylitol Gum*
- *Resources*
- *Education*
- *Support*

CTTP Locations

Fontana
Bloomington
Rialto
Loma Linda
San Bernardino
Victorville
Apple Valley
Barstow
Yucca Valley
Joshua Tree

To Enroll or For Further Information, Contact:

Maribel Muñoz, Program Manager
(909) 558-5400 Fax 909-558-3935

Diana Shouman-Garcia, Perinatal Health Specialist
(909) 558-3264

Eva Arambula, Perinatal Health Specialist
(909) 558-3180

Se Habla Español

LOMA LINDA UNIVERSITY
CHILDREN'S HOSPITAL

11215 Mountain View Ave, Suite 179
Loma Linda, CA 92354

Please fill out and mail or Fax the following if you are interested.

I am interested in receiving information about Comprehensive Tobacco Treatment Program and would like to be contacted for more information.

Name: _____ Signature: _____

City: _____ Phone: _____

Referred By: _____

When Sexual Intercourse* with a Minor Must Be Reported as Child Abuse: California Law

In California, health care practitioners are mandated to report any reasonable suspicion of child abuse. Sexual intercourse with a minor is reportable as child abuse *when*:

1. WHEN COERCED OR IN ANY OTHER WAY NOT VOLUNTARY

Mandated reporters must report any intercourse that was coerced or in any other way not voluntary, irrespective of the ages of the partners and even if both partners are the same age. Sexual activity is not voluntary, for example, when accomplished against the victim's will by means of force or duress, or when the victim is unconscious or so intoxicated that he or she cannot resist. *See* Penal Code § 261 for more examples. Irrespective of what your patient tells you, treating professionals should use clinical judgment and "evaluate facts known to them in light of their training and experience to determine whether they have an objectively reasonable suspicion of child abuse." 249 Cal. Rptr. 762.

2. BASED ON AGE DIFFERENCE BETWEEN PARTNER AND PATIENT IN A FEW SITUATIONS

Mandated reporters also must report based on the age difference between the patient and his or her partner in a few circumstances, according to the following chart:

KEY: M = *Mandated. A report is mandated based solely on age difference between partner and patient.*
CJ = *Clinical Judgment. A report is not mandated based solely on age; however, a reporter must use clinical judgment and must report if he or she has a reasonable suspicion that act was coerced, as described above.*

Age of Partner ⇒ / Age of Patient ⇓	12	13	14	15	16	17	18	19	20	21	22 and older
11	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
12	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
13	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
14	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇒
15	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇒
16	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
17	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
18	M	M	CJ	CJ	CJ	CJ					
19	M	M	CJ	CJ	CJ	CJ					
20	M	M	CJ	CJ	CJ	CJ					
21 and older	M	M	M	M	CJ	CJ					

Chart design by David Knopf, LCSW, UCSF.
(*The legal sources for this chart are as follows*: Penal Code §§ 11165.1; 261.5; 261; 259 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1989); 226 Cal. Rptr. 361, 381 (1st Dist. Ct. App. 1986); 73 Cal. Rptr. 2d 331, 333 (1st Dist. Ct. App. 1998).

Do I have a duty to ascertain the age of a minor's sexual partner for the purpose of child abuse reporting?

No statute or case obligates health care practitioners to ask their minor patients about the age of the minors' sexual partners for the purpose of reporting abuse. Rather, case law states that providers should ask questions as in the ordinary course of providing care according to standards prevailing in the medical profession. Thus, a provider's professional judgment determines his practice. 249 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1988).

What do I do if I am not sure whether I should report something?

When you aren't sure whether a report is required or warranted, you may consult with Child Protective Services and ask about the appropriateness of a referral.

*This worksheet addresses reporting of consensual vaginal intercourse between **non-family members**. It is not a complete review of all California sexual abuse reporting requirements and should not be relied upon as such. For more information on other reporting rules and how to report in California and other states, check www.teenhealthrights.org

Prenatal Exposures - Referral

MotherToBaby
Medications & More During Pregnancy & Breastfeeding
Ask The Experts

Toll- Free (877) 311-8972

Fax (858) 246-1710

Fax Referral Form MotherToBaby Studies conducted by OTIS

Patient's Name: _____

Patient's home number: _____Patient's cell/work number_____

Preferred language: _____

Preferred contact day: [ ] Mon [ ] Tues [ ] Wed [ ] Thurs [ ] Fri [ ] Anytime

Preferred contact time: _____ [ ] a.m. [ ] p.m. [ ] Anytime

May we leave a message? [ ] Yes [ ] No

Less than 20 week of gestation: [ ] Yes [ ] No

Estimated Due Date: _____

Patient has:

[ ] Autoimmune Disease:
- [ ] Ankylosing Spondylitis
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Fibromyalgia
- [ ] Psoriatic Arthritis
- [ ] Psoriasis
- [ ] Rheumatoid Arthritis

[ ] Physician-diagnosed Asthma or use of Asthma medications

[ ] Exposure to one or more of the following:
- [ ] Seasonal flu vaccine [ ] Flumist
- [ ] Oseltamivir (Tamiflu) [ ] Zanamivir (Relenza)

[ ] Non-diseased controls:

Referred by : _____ Date referred: _____
Last Name

Patient agrees to be contacted by the Coordinating Center for OTIS Studies

[ ] Verbal consent
[ ] Written consent

Signature: _____

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

WIC REFERRAL FOR PREGNANT WOMEN

Health Care Provider: Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate (MM/DD/YY)

WOMAN'S CURRENT (PRENATAL)

Height _____ ins. Measurement date _____ Hemoglobin _____ gm/dl. Blood test date _____

and/or

Weight _____ lbs. _____ Hematocrit _____ % _____

Est. date confinement _____

Date last preg. ended _____

Gravida _____ Para _____

Pregravid weight _____ lbs.

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:

- ☐ Diabetes
- ☐ Multiple Pregnancy
- ☐ Hypertension
- ☐ Tuberculosis _____ +PPD _____ INH
- ☐ Previous poor pregnancy outcome / history (specify):
- ☐ Other current or historical conditions (specify):

PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

Name of physician/health care provider/group/clinic	Telephone number

LOCAL WIC AGENCY

IMPORTANT: Must be signed by health care provider Date

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

CDPH

This institution is an equal opportunity provider.

CDPH 247C Rev 04/17 | #930028

WIC

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

WIC REFERRAL FOR POSTPARTUM/BREASTFEEDING WOMEN

Health Care Provider: Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate (MM/DD/YY)

WOMAN'S CURRENT (After Delivery)

Height _____ ins.

Weight _____ lbs.

Measurement date _____

Hemoglobin _____ gm/dl.

and/or

Hematocrit _____ %

Blood test date _____

PREGNANCY OUTCOME

Delivery date _____

	Full-term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth	Sex	Birth weight	Birth length
1.	☐	☐	☐	☐	☐			
2.	☐	☐	☐	☐	☐			

Please describe any medical conditions affecting the infant(s):

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

- ☐ C-Section
- ☐ Diabetes
- ☐ Hypertension
- ☐ Tuberculosis
- ☐ Other conditions occurring during this pregnancy for delivery (specify):
- ☐ Other current or historical medical conditions (specify):

_____ +PPD _____ INH

LOCAL WIC AGENCY

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

Name of physician/health care provider/group/clinic	Telephone number:

IMPORTANT: Must be signed by health care provider

Date

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

CDPH

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CDPH 247B Rev 04/17 | #930028

WIC

State of California — Health and Human Services Agency

California Department of Public Health — WIC Program

Pediatric Referral

WIC Agency:

WIC ID#:

SECTION I: ***Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals. Whenever a therapeutic formula is prescribed, complete both Sections I and II.***

PATIENT NAME: (First) (Last)				DATE OF BIRTH:
CURRENT HEIGHT/LENGTH: (within 60 days) inches	CURRENT WEIGHT: (within 60 days) lbs oz	CURRENT BMI: (within 60 days) BMI percentile: %	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH: lbs oz inches

HEMOGLOBIN OR HEMATOCRIT TEST is required every 12 months when normal and every 6 months when abnormal.

Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result Date

LEAD TEST (recommended at 1–2 years of age): _____ mcg/dL

IMMUNIZATIONS are up-to-date:

☐ Yes ☐ No ☐ Not available

BREASTFEEDING ASSESSMENT (birth to 12 months):

☐ Fully breastfeeding ☐ Never breastfed ☐ Feeding breastmilk & formula ☐ Discontinued breastfeeding (Date: _____)

SECTION II: ***Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay issuance of WIC foods.***

DIAGNOSIS:

☐ Prematurity ☐ GERD or reflux ☐ Food allergy: _____

☐ Failure to thrive ☐ Dysphagia ☐ Other: _____

FORMULA / MEDICAL FOOD: _____

DURATION: _____ months **AMOUNT:** _____ oz / day

This prescription is: ☐ New ☐ Refill

NOTE: At 1 year of age, the patient will receive 13 quarts of cow's milk in addition to therapeutic formula unless *Do Not Give* is checked for cow's milk (see WIC Food Restrictions).

COMMENTS:

WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.

Category	WIC Foods	Do Not Give	Restriction / Comment
Infants (6–12 mo)	Baby cereal		
	Baby fruit / vegetable		
Children (1–5 yr)	Cow's milk		
	Cheese		
	Eggs		
	Peanut butter		
	Whole grains *		
	Cereal		
	Beans		
	Vegetables / fruits		
	Juice		
	Yogurt		

*** whole wheat bread, corn/wheat tortilla, brown rice, barley, bulgur, or oatmeal**

HEALTH COVERAGE: ***Refer patient to their health plan or Medi-Cal for a medically necessary formula or medical food.***

WIC only provides these products when they are NOT a covered benefit by the patient's health plan or by Medi-Cal.

Provide patient's health insurance information:	Check action taken:
Private insurance: _____ Medi-Cal managed care: _____ Other: _____	☐ Submitted justification to health plan
Regular Medi-Cal (fee-for-service): ☐ Yes ☐ No	☐ Submitted justification to pharmacist

If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:

☐ Gave formula samples

☐ Referred to Medi-Cal

☐ Referred to WIC

QUESTIONS: Call 1-888-942-9675 or 1-800-852-5770.
Health Professionals: Go to www.wicworks.ca.gov; click Health Care Professionals; then click WIC contacts for MDs.

COMMENTS:

HEALTH PROFESSIONAL NAME	HEALTH PROFESSIONAL SIGNATURE	MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP
PHONE NUMBER	TODAY'S DATE	

CDPH 247A Rev 03/16 | #930029

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER | TITLE | MANDATED REPORTER CATEGORY

REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS | Street | City | Zip | DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO

REPORTER'S TELEPHONE (DAYTIME) ( ) | SIGNATURE | TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services) | AGENCY

ADDRESS | Street | City | Zip | DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - TITLE | TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | TELEPHONE ( )

PRESENT LOCATION OF VICTIM | SCHOOL | CLASS | GRADE

PHYSICALLY DISABLED? ❒ YES ❒ NO | DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO | OTHER DISABILITY (SPECIFY) | PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? ❒ YES ❒ NO | IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME | TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)

RELATIONSHIP TO SUSPECT | PHOTOS TAKEN? ❒ YES ❒ NO | DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME | BIRTHDATE | SEX | ETHNICITY

1. _____
2. _____
3. _____
4. _____

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | TELEPHONE ( )

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ | *IF MULTIPLE VICTIMS, INDICATE NUMBER:*

DATE / TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

Prenatal Dental Health Referral

Name of Prenatal Provider:

Address:

Phone:

Fax:

This patient is cleared for routine evaluation and dental care.

Patient Name:_____ Date:_____

Patient's dental concerns: ❒ pain ❒ swelling ❒ infection
❒ possible gum disease ❒ possible tooth decay ❒ loose or broken tooth
❒ no dental care in over one year ❒ other: _____

Patient is approved for dental services including:

❒ cleaning
❒ x-rays with abdominal and thyroid shielding
❒ extractions and fillings
❒ local anesthesia (lidocaine preferred; etidocaine and prilocane also considered safe)
❒ antibiotics (amoxicillin, penicillin, erythromycin (base), cephalosporins, clavulanate and clindamycin)
❒ analgesia (acetaminophen preferred; acetaminophen with oxycodone for short term management of acute pain; non-steroidal anti-inflammatory agents such as ibuprofen used with caution before the third trimester)

Weeks pregnant: _____ **Due date**: _____

Significant medical conditions:_____

_____

PPD result: _____ **If positive, chest X-ray result**:_____

Current medications:_____

Medication allergies:_____

_____

Signature of Obstetrical Provider_____

Suspicious Injury Report Sample

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (4/1/09)

STATE OF CALIFORNIA

INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER ☐ M ☐ F	4. SAFE PHONE NUMBER ( )

5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt – **NO P.O. Box**) City State Zip

6. PATIENT SPEAKS ENGLISH ☐ Y ☐ N – Identify language spoken: _____	7. DATE AND TIME OF INJURY Date: Time: ☐ am ☐ pm ☐ Unknown

8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE – Check here if unknown: ☐

9. PATIENT'S COMMENTS ABOUT THE INCIDENT – Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT – If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY

12. SUSPICIOUS INJURY DESCRIPTION – Include a brief description of physical findings and the final diagnosis. ☐ ADDITIONAL PAGES ATTACHED

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: Time: ☐ am ☐ pm

15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE	17. PHONE NUMBER ( )

18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)	19. AGENCY INCIDENT NUMBER

Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ( )

22. EMPLOYER'S ADDRESS (Number and Street) City State Zip

23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE

25. HEALTH PRACTITIONER'S SIGNATURE:	26. DATE SIGNED:

Resource list - 211- SEARCH ONLINE or call 211

211 SAN BERNARDINO COUNTY IS:

- A 24/7 Call Center
- Always answered by a live person
- The most comprehensive database of free and low cost health and human services available
- A free and confidential phone call whether dialing 2-1-1 directly, or 888-435-7565
  Staffed by professional, trained, caring people who give information &referrals to appropriate resources
- A joint United Way operation between Inland Empire, Arrowhead, Desert Communities, Mohave Valley and United Way of the Desert

Every day, thousands of people find themselves in circumstances where, often for the first time, they need resources that can't be found in the yellow pages or on the internet: low cost burial services, employment, a free or low-cost health clinic, training, free eyeglasses replacement for the elderly, affordable parenting classes or other counselling, legitimate help overcoming temporary financial difficulties, and many more such scenarios. 2-1-1 has the answers.

2-1-1 PROGRAM GOAL

The goal of 2-1-1 is to provide timely, effective access to accurate and comprehensive information and referral for the residents of San Bernardino County, and provide public information support in times of disaster.