## CPSP Integrated Initial [I] and [2]& [3]Trimester Assessments and Individualized Care Plan

**Client Orientation:**
❑ Client orientation per protocol ❑ States understands **Welcome to Pregnancy Care** ❑ States understands CPSP is voluntary and agrees to participate ❑Reviewed STT HE, **Pregnant? Steps for a Healthy Baby** ❑Vitamins per protocol
Minutes:_____Signature:_____
Date of Orientation: _____
Document additional Orientation in Progress Note

Client Identifier

## Pregnancy Information

DOB:_____Age:_____

EDD:_____Weeks Gestation_____

Grav:_____Para:_____TAB:_____SAB:_____

**OB problem list reviewed, if available, before conducting assessments.**
❑1st TM ❑2nd TM ❑3rd TM

**Assessment: Complete all items regardless of which trimester client begins care**

## Psychosocial:

| **Psychosocial Needs/Risks/Concerns** *(ask questions in Initial, 2nd or 3rd trimester as indicated)* | **Psychosocial Individualized Care Plan Developed with Client** | **Comment** |
|---|---|---|
| 1. Is this a planned pregnancy? ❑Yes ❑ No, describe:<br>[I]<br>2. Is this a wanted pregnancy? ❑Yes ❑ No, describe:<br>3. Are you considering abortion/adoption? ❑No ❑ Yes, describe: | ❑ Client states she understands STT PSY, ❑ **Uncertain about Pregnancy, ❑ Choices**<br>❑ Client goal/plan:<br>❑ Informed of CA Safe Surrender Law<br>❑ Consult with OB provider<br>❑ Referred to/for: | |
| 4. How does the FOB/Partner feel about the pregnancy? ❑ Happy ❑ Involved ❑ Upset ❑ FOB/Partner not sure ❑ Uninvolved ❑ FOB/Partner doesn't know ❑ Client doesn't know how partner feels<br>[I]<br>❑ Client wishes more support, identified sources: | ❑ Referred to/for:<br>❑ Client goal/plan: | |
| 5. What are your goals for this pregnancy?: ❑ healthy baby<br>[I] ❑ other: | ❑ Referred to/for:<br>❑ Client goal/plan: | |
| 6. Have you had issues with previous pregnancies? ❑ N/A<br>[I] ❑ No ❑ Yes, describe:<br>❑ Would you like information on how to reduce risk in this pregnancy? ❑Yes ❑ No | ❑ Client goal/plan:<br>❑ Consult with OB provider | |
| 7. Have you had a previous pregnancy loss/infant death?<br>[I] ❑No ❑ Yes, describe: | ❑ Client goal/plan:<br>❑ Client states aware of support resources<br>❑ Referred to/for: | |
| 8. Members of household (not including client)<br>[I] Number of adults: _____<br>Relationship to client:<br>Number of children: _____<br>Relationship to client:<br>9. Do all of your children live with you? ❑ N/A ❑ Yes ❑ No, describe: | ❑ Client goal/plan:<br>❑ Referred to/for | |
| 10. Are you currently receiving services from a local agency such as case management, home visiting, counseling etc.?<br>[I] ❑ No ❑Yes, describe: | ❑ Client goal/plan:<br>❑ Obtained client's written permission to share information with:<br>Agency:_____<br>Contact person:_____<br>Phone: _____ Fax:_____ | |

Client Identifier

| **Psychosocial Needs/Risks/Concerns** *(ask questions in Initial, 2nd or 3rd trimester as indicated)* | **Psychosocial Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| ❑ No ❑ Yes, describe:<br>2 | ❑ Client goal/plan:<br>❑ Obtained client's written permission to share information with:<br>Agency:_____<br>Contact person:_____<br>Phone: _____ Fax:_____ | |
| ❑ No ❑ Yes, describe:<br>3 | ❑ Client goal/plan:<br>❑ Obtained client's written permission to share information with:<br>Agency:_____<br>Contact person:_____<br>Phone: _____ Fax:_____ | |
| 11. Have you ever seen a counselor for personal or family issues or support? ❑ No ❑ Yes, describe:<br>I<br>Do you need counseling now? ❑ No ❑ Yes, describe: | ❑ Client goal/plan:<br>❑ Referred to/for: | |
| 12. Have you ever been emotionally, physically, or sexually abused by a partner or someone close to you?<br>❑ No ❑ Yes, describe:<br>I<br>13. Within the last year, have you ever been hit, slapped, kicked, pushed, shoved, forced to have sex, forced to get pregnant or otherwise physically hurt by your partner or ex-partner?<br>❑ No ❑Yes, by whom?<br>Do you have injuries now? ❑ No ❑ Yes, describe:<br>Do you feel in danger now? ❑ No ❑ Yes, describe: | ❑ Client Goal/plan:<br>❑ States understands STT PSY **Cycle of Violence**<br>❑ Made safety goal/plan ❑ Client states understands legal options ❑ Agrees to follow STT PSY: **Safety When Preparing to Leave**<br>❑ Referred to/for:<br>❑ If minor, completed mandated report, date:_____<br>❑ If current injuries/adult, reported to OB provider<br>❑ Reported to law enforcement, date:_____<br>❑ In contact with law enforcement/agency already: | |
| 14. Are you afraid of your partner or ex-partner?<br>I ❑ No ❑ Yes, describe:<br>2 ❑ No ❑ Yes, describe:<br>3 ❑ No ❑ Yes, describe: | ❑ Client goal/plan: states understands:<br>❑ STT PSY **Cycle of Violence**<br>❑ What to do in an emergency ❑ Legal options. ❑ Agrees to follow STT PSY: **Safety When Preparing to Leave**<br>❑ Made safety plan<br>❑ Referred to/for:<br>Update:<br>Update: | |
| 15. Are you having any other personal or family challenges?<br>I ❑ No ❑ Yes, describe:<br>2 ❑ No ❑ Yes, describe:<br>3 ❑ No ❑ Yes, describe: | ❑ Client states aware of support resources:<br>❑ Client goal/plan:<br>❑ Referred to/for:<br>❑ Update:<br>❑ Update: | |
| 16. Who do you turn to for emotional support?<br>I ❑ FOB/partner ❑ family member:<br>❑ friend: ❑ other:<br>❑ No one, describe:<br>2 ❑ No one, describe:<br>3 ❑ No one, describe: | ❑ Client identified possible sources of support<br>❑ Client goal/plan:<br>❑ Referred to/for:<br>❑ Update:<br>❑ Update: | |

Client Identifier

| **Psychosocial Needs/Risks/Concerns** *(ask questions in Initial, 2nd or 3rd trimester as indicated)* | **Psychosocial Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| 17. Do you often feel down, sad or hopeless? ❑No<br>I ❑ Yes, describe:<br><br>Do you often feel irritable, restless or anxious? ❑No<br>❑ Yes, describe:<br><br>Have you lost interest or pleasure in doing things that you used to enjoy? ❑ No ❑ Yes, describe:<br><br>2 Ask the above questions, describe response:<br><br>3 Ask the above questions, describe response: | ❑ Screen for signs of emotional concerns at future appointments<br>❑ Referred to ❑provider or ❑psychosocial consultant for assessment and intervention<br>❑ Client goal/plan:<br><br>❑ Referred to:<br><br>Update:<br><br>Update: | |
| 18. Did your parents use alcohol or drugs? ❑No ❑ Yes, describe:<br>I<br>19. Does your partner use alcohol or drugs? ❑ N/A ❑No<br>❑ Yes, describe: | ❑ Client states understands risks ❑ Client goal/plan:<br><br>❑ Referred to/for: | |
| 20. Before you knew you were pregnant, how much beer/wine/liquor did you drink? ❑ None<br><br>I ❑ was drinking _____ _____a day/wk./month<br>amount type of alcohol<br><br>Are you drinking now? ❑ No ❑ Yes, describe:<br>_____ _____a day/wk./month<br>amount type of alcohol<br><br>Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_____a day/wk./month<br>times | ❑ Client states understand risks ❑ Client goal/plan:<br>❑ Follow STT PSY, **Baby Can't Say No**<br>❑Follow STT PSY, **Drugs and Alcohol, when you want to STOP using**<br>❑ Client states decided not to drink alcohol<br>❑ Agreed to cut down to how much: _____<br>Client stated confidence in quitting/cutting down:<br>(circle): 1 2 3 4 5 6 7 8 9 10<br>❑ Support person:<br>❑ Consult with OB provider<br>❑ Referred to/for: | |
| 2 Are you drinking now? ❑ No ❑ Yes, describe:<br>_____ _____a day/wk./month<br>amount type of alcohol<br><br>Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_____a day/wk./month<br>times | Update: | |
| 3 Are you drinking now? ❑ No ❑ Yes, describe:<br>_____ _____a day/wk./month<br>amount type of alcohol<br><br>Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_____a day/wk./month<br>times | Update: | |
| 21. Before you knew you were pregnant, how much tobacco did<br>I you smoke (including e-cigarettes)? ❑None<br>❑ was smoking (amount, type, how often) _____<br>_____<br><br>Are you smoking now? ❑ No<br>❑ Stopped smoking and is not smoking now<br>❑ Cut down to _____ | ❑ Client states understands risks ❑ Client goal/plan:<br>❑ Will cut down to how much_____<br>❑ Will quit when_____<br><br>❑Client's confidence in quitting (circle):<br>1 2 3 4 5 6 7 8 9 10<br><br>❑ Identified support person: | |

Client Identifier

| **Psychosocial Needs/Risks/Concerns** *(ask questions in Initial, 2nd or 3rd trimester as indicated)* | **Psychosocial Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| ❑ Smoking about the same amount | ❑ States understands STT HE: **You can Quit Smoking**<br>❑ Referred to CA Smokers' Helpline 1-800-NoButts<br>❑ Consult with OB provider<br>❑ Referred to/for: | |
| 2 Are you smoking now? ❑Yes ❑ No<br>❑ Stopped smoking and is not smoking now<br>❑ Cut down to_____<br>❑ Smoking about the same amount | Update: | |
| 3<br>Are you smoking now? ❑Yes ❑ No<br>❑ Stopped smoking and is not smoking now<br>❑ Cut down to_____<br>❑ Smoking about the same amount | Update: | |
| 22. Do people smoke around you? ❑ No<br>I<br>❑ Yes, about _____hours per day<br>Number<br>2 ❑ No ❑ Yes, about _____hours per day<br>Number<br>3 ❑ No ❑ Yes, about _____hours per day<br>Number | Client goal/plan:<br>❑ States will avoid smoke<br>❑ States will talk to others about keeping home and car smoke-free ❑ Discussed STT HE section, *Second Hand Smoke*❑ **You can Quit Using Drugs or Alcohol**<br>❑ Update:<br>❑ Update: | |
| 23. Before you knew you were pregnant, how much did you usually use marijuana or other drugs? ❑ None<br>I<br>❑ Was using:_____ _____a day/wk./month<br>amount drug<br>Are you using drugs now? ❑ No<br>❑ Yes, now using:_____ _____a day/wk./month<br>amount drug | ❑ Client verbalizes understanding of risks. Client goal/plan:<br>❑Client understands STT HE: **You can Quit Using Drugs or Alcohol**<br>❑ Has decided to: ❑ cut down to how much_____<br>❑ not to use any drugs ❑ Client's confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10<br>❑ Support person:<br>❑ Consult with OB provider<br>❑ Referred to/for:<br>❑ Obtained client's written permission to exchange information with:<br>Agency:_____<br>Contact person:_____<br>Phone: _____ Fax:_____ | |
| 2 Are you using drugs now? ❑ No<br>❑ Yes, using:_____ _____a day/wk./month<br>amount drug | Update: | |
| Are you using drugs now? ❑No<br>❑ Yes, now using:_____ _____a day/wk./month<br>3 amount drug | Update: | |
| 24. What is your source of financial support?<br>I ❑ Self, type of work:<br>❑ FOB/partner, type of work:<br>❑ Family member/ friend:<br>❑ CalWORKS ❑ SSI ❑ other: | ❑ Client Goal/plan:<br>❑ Referred to/for: | |

Client Identifier

| **Psychosocial Needs/Risks/Concerns** *(ask questions in Initial, 2nd or 3rd trimester as indicated)* | **Psychosocial Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| ❑ Concerns, describe:<br><br>2 ❑ Concerns, describe:<br><br>3 ❑ Concerns, describe: | <br><br>Update:<br><br>Update: | |
| 25. Where do you live?<br>I ❑ Apartment/house ❑ other: _____<br>❑ Concerns, describe:<br><br>2 ❑ Concerns/changes, describe:<br><br>3 ❑ Concerns/changes, describe: | ❑ Client Goal/plan:<br>❑ Referred to/for:<br><br>Update:<br><br>Update: | |
| 26. Any other questions or concerns?<br>I ❑ None ❑ Yes, describe:<br><br>2 ❑ None ❑ Yes, describe:<br><br>3 ❑ None ❑ Yes, describe: | ❑ Client Goal/plan:<br>❑ Referred to/for:<br><br>Update:<br><br>Update: | |
| 27. Discussed results of assessment with client and client identified the following strengths:<br><br>I<br><br>2<br><br>3 | | |

## Psychosocial

I Minutes spent _____ Completed by: _____ _____ _____
Signature Title Date

Signature of medical provider *if assessor is CPHW*: _____ _____ _____
Signature Title Date

2 Minutes spent _____ Completed by: _____ _____ _____
Signature Title Date

3 Minutes spent _____ Completed by _____ _____ _____
Signature Title Date

Client Identifier

## Health Education

| **Health Education Learning Needs/Risks/Concerns** (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell) | **Health Education Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| 1. How do you like to learn?: ❑ Reading/handouts ❑ Individual teaching ❑ Other: ❑ Text message reminders ❑ Classes/groups ❑ Videos<br>How well do you write/read? ❑ good/fair ❑ poor/non-reader<br>I<br><br>2. Do you have someone you can talk to about what we discussed today? ❑ Yes, identify _____ ❑ No | ❑ Will use following learning methods:<br>❑ Client wishes adapted education methods, such as using pictures or low literacy materials<br>❑ Will sign up for Text4Baby<br><br>❑ Client stated she will involve a support person by sharing educational materials after her appointments<br>Name/relationship: | |
| 3. What language do you prefer to speak? _____<br>What language do you prefer to read? _____<br>In what language would you like materials?_____<br>I | ❑ Provide materials in _____language. | |
| 4. What was the last grade you completed?_____<br>I ❑ Less than high school/GED | ❑ Referred to: | |
| 5. How long have you lived in this area? ❑ More than a year ❑ Less than one year<br>Do you plan to stay in this area for the rest of your pregnancy?<br>❑ Yes ❑ No, comments:<br><br>Do you know how to get other health care services?<br>I ❑Yes ❑ No, comments: | ❑ Client verbalizes understanding of available health care services<br>❑Provide a copy of her medical records if she needs to leave the area.<br>❑ Referred to: | |
| 6. Do you have any physical difficulties that affect learning? (Such as vision, hearing, learning disabilities)? ❑No<br>I ❑ Yes, describe: | ❑ Client wishes adapted health education methods<br>❑ Consult with OB provider<br>❑ Referred to/for: | |
| 7. Who gives you advice about your pregnancy? ❑ No one<br>I ❑ mother ❑ mother-in-law ❑ grandmother<br>❑ partner ❑ sister ❑ friend:<br>❑ other:<br><br>What are the most important things they have told you? | ❑ Referred to support group: _____<br>❑ Client stated she will consult with OB provider regarding the following possibly harmful advice: | |
| 8. Are you exposed to any of the following at work or home?<br>I ❑ chemicals, fumes, pesticides, lead<br>❑ cats ❑ rodents ❑ douching<br>❑ hot baths ❑ x-rays ❑ other:<br>❑ No, none of the above | Client goal/plan: ❑ Follow STT HE **Pregnant? Steps for a Healthy Baby ❑Keep Safe at Work**<br>❑ Consult with OB provider re:<br><br>❑ Client has MotherToBaby California information (866) 626-6847 www.mothertobabyca.org<br>❑ Mailed or faxed MotherToBaby client referral form | |
| 9. We ask all clients this question: do you have any of these risk factors for diseases like chlamydia, gonorrhea, herpes, or HIV?<br>❑More than one sexual partner?<br>❑Ever had sex while using alcohol or drugs?<br>❑ Have you or any partners ever had an STD?<br>❑ Has your partner had sex with anybody else?<br>❑Have you or any partners exchanged sex for drugs, money, or shelter?<br>❑Have you or any partners ever injected drugs not prescribed by a doctor? | ❑ Client agrees to follow STT HE ❑ **What you Should Know about STDs ❑What you should Know about HIV ❑You Can Protect Yourself and Your Baby from HIV**<br>❑Referred to: | |
| 10. Which of the following topics would you like to learn about?<br>I ❑ Body changes during pregnancy, ❑ Baby's growth,<br>❑ Immunizations for pregnant women (flu, Tdap)<br>❑ other topics, describe:_____<br><br>❑ None, follow up at next visit | ❑ Reviewed the following items with client:<br><br>❑ Client will discuss the following with OB provider:<br><br>❑ Reviewed the following items with client: | |

Client Identifier

| **Health Education Learning Needs/Risks/Concerns** (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell) | **Health Education Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| 2 ❑ No, follow up at next visit ❑ Yes, describe topics:<br><br>3 ❑ No , follow up at next visit ❑ Yes, describe topics: | ❑ Client will discuss the following with OB provider:<br><br>❑ Reviewed the following items with client:<br><br>❑ Consult with OB provider re: | |
| 11. Have you had a dental check-up in the past 12 months?<br>I Date: _____ ❑ No:<br><br>Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe:<br><br>2 Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe: :<br><br>*If referred: Have you seen a dentist? Date:*_____<br><br>3 Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe:<br><br>*If referred: Have you seen a dentist? Date:*_____ | Client Goal/plan: Follow STT HE ❑ **Prevent Gum Problems**<br>❑ **See a Dentist** ❑ **Keep Teeth Healthy**<br>❑ Consult with OB provider<br>❑ Completed Prenatal Dental Referral, date: _____<br>❑ Referred to/for:<br><br>❑ Update:<br><br>❑ Update: | |
| 12. How will you come for appointments?<br>I ❑ bus ❑ car ❑ walk ❑ other:<br>❑ Any transportation issues? Describe:<br><br>2 ❑ Any transportation issues? Describe:<br><br>3 ❑ Any transportation issues? Describe: | ❑ Client goal/plan:<br><br>❑ Client goal/plan:<br><br>❑ Client goal/plan: | |
| 13. Do you know how to use a seat belt when pregnant?<br>I ❑ Yes ❑ No<br><br>2 Do you always use a seat belt?<br>❑ Yes ❑ No<br><br>3 Do you always use a seat belt?<br>❑ Yes ❑ No | ❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby**<br><br>❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby**<br><br>❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby** | |
| 14. Can you describe what you think might be pregnancy danger signs, symptoms of preterm labor, labor induction, and when to call the doctor for prenatal concerns?<br>I ❑ Yes ❑ No, list gaps:<br><br>2 Discussed above items: ❑ Yes ❑ No, list gaps:<br><br>3 Discussed above items ❑ Yes ❑ No, list gaps: | Client goal/plan: Follow: STT HE ❑ **Danger Signs in Welcome to Pregnancy Care**<br>❑ **If Labor Starts Too Early**<br>❑ **What You Need to Know About Labor Induction**<br>❑ Consult with OB provider<br><br>Client goal/plan: Follow: STT HE ❑ **Danger Signs in Welcome to Pregnancy Care** ❑ **If Labor Starts Too Early**<br>❑ **What You Need to Know About Labor Induction**<br>❑ Consult with OB provider<br><br>Client goal/plan: ❑ Client is more than 28 weeks and will follow ❑ STT HE **Kick Counts** ❑ **Danger Signs in Welcome to Pregnancy Care** ❑ **If Labor Starts Too Early**<br>❑ **What You Need to Know About Labor Induction**<br>❑ Consult with OB provider | |
| 15. What are your plans for labor and delivery?<br>3 labor support person ❑ Yes ❑ No<br>signs of labor, when to call ❑ Yes ❑ No<br>goal/plans for transportation to hospital ❑ Yes ❑ No<br>childcare goal/plans for other kids ❑ Yes ❑ No<br><br>16. Do you have any questions about how to take care of yourself | ❑ Referred to hospital tour: Name of hospital: _____<br>❑ Referred to childbirth preparation class_____<br>❑ Understands options for labor and delivery<br>❑ Reviewed/completed STT NUT **My Birth Plan**<br>❑ Client understands signs of labor, when to call<br>❑ Client has support person:<br>❑ Client has made arrangements for transportation to | |

Client Identifier

| **Health Education Learning Needs/Risks/Concerns** (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell) | **Health Education Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| after delivery? ❑ No ❑ Yes, describe:<br><br>❑ Discussed importance of postpartum care, procedure for making appointments. | hospital ❑ Client has made arrangements for childcare for other kids<br>❑ Client has no support person—notified<br>_____<br>❑ Client understands importance of postpartum care and has agreed to make appointment | |
| 17. Do you know about infant: ❑ care, ☐safety, ☐ illness,<br>3 ☐ safe sleep, ☐ immunizations?<br><br>18. Do you have the following items?<br>❑ baby supplies/clothing/safe sleeping<br>❑ child passenger safety seat<br>❑ Child care, if returning to work or school<br>❑Needs: | Client Goal/plan: Follow: STT HE<br>❑ **Keep Your New Baby Safe and Healthy**<br>❑ **When Newborn is Ill**<br>❑ **Baby Needs Immunization**<br>❑ If multiples, **Getting Ready for Multiples, Baby Products, Discounts, and Coupons**<br>❑ Client has car seat/understands car seat requirements<br>❑ Client understands crib safety (crib slats no more than 2 3/8 inches apart and other tips)<br>❑ Advised to call:<br><br>❑ Referred to/for: | |
| 19. Have you chosen a doctor for the baby? ❑ Yes ❑ No<br>3 Name of provider_____ | ❑ Referred to pediatric provider: _____<br>❑ Referred to CHDP provider: _____ | |
| 20. Do you plan to have more children? ❑ Yes ❑ No<br>How many? _____<br><br>3 How far apart? _____<br><br>What birth control method(s) are you interested in?<br><br>Do you have any concerns about your ability to use birth control? ❑ No ❑ Yes, describe:<br>❑ Remembering to use birth control<br>❑ Concerned about failure<br>❑ Partner interferes with birth control | ❑ Has family planning provider<br>❑ Discussed birth control methods, including long acting contraceptives (LARCs)<br>❑ Preferred contraceptive method: _____<br>❑ Referred to family goal/planning provider<br>❑ Client will consult with obstetric provider if planning to get pregnant again before this baby is 18 months old.<br>❑ Client will consult with OB provider if client's partner does not support her use of birth control.<br>❑ Client understands there are methods partner does not have to know about. | |
| 21. Do have a doctor you can go to for regular medical checkups?<br>3 ❑ Yes Name: _____<br>❑ No | ❑ Client will call: Name:_____<br>❑ Referred to/for: | |
| 22. Do you have health insurance for care after your pregnancy?<br>3 ❑ Yes ❑ No | ❑ Referred to eligibility worker, Covered CA or safety net | |
| 23. Has your doctor told you that you have any health problems<br>3 that need follow up after your pregnancy? *(diabetes, high blood pressure, obesity, depression etc.)* ❑No ❑ Yes, describe: | Client goal/plan:<br>❑ Make appointment with primary care provider<br>❑ Referred to/for: | |
| 24. Do you have any other questions or concerns?<br>I ❑ No ❑ Yes, describe:<br><br>2 ❑ No ❑ Yes, describe:<br><br>3 ❑ No ❑ Yes, describe: | Client goal/plan:<br><br>Client goal/plan:<br><br>Client goal/plan: | |
| 25. Reviewed health education assessment with client and client identified the following strengths:<br>I<br><br>2 | | |

Client Identifier

| **Health Education Learning Needs/Risks/Concerns** (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell) | **Health Education Individualized Care Plan Developed with Client** | **Com-ment** |
|---|---|---|
| 3 | | |

## Health Education:

I Minutes spent _____ Completed by: _____ _____ _____
Signature Title Date

Signature of medical provider *if assessor is CPHW*: _____ _____ _____
Signature Title Date

2 Minutes spent _____ Completed by: _____ _____ _____
Signature Title Date

3 Minutes spent _____ Completed by _____ _____ _____
Signature Title Date

Client Identifier

## Nutrition

| **Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated) | **Nutrition Individualized Care Goal/plan Developed with Client** | **Com-ment** |
|---|---|---|
| **Anthropometric: Height, Weight, & Body Mass Index (BMI)** | | |
| 1. Pre-pregnancy weight: _____ lbs. Height_____BMI_____<br>I BMI category/Weight Gain Grid used:<br>❑ Underweight ❑ Normal ❑ Overweight ❑ Obese<br><br>❑ Currently pregnant with multiples?<br>❑ Twins ❑ Triplets or more (consult w/ provider for wt. gain goal)<br><br>During previous pregnancy how much weight did you gain?<br>_____lbs. ❑N/A | *Client states understanding of:*<br>❑ Pre-pregnancy weight category (BMI)<br>❑ Recommended weight gain range for pre pregnancy weight category is between ____ lbs. and _____lbs.<br>❑ Plotting and discussing weight gain at every visit<br><br>❑ Client's weight gain goal for this pregnancy: _____<br><br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____ | |
| 2. Current weight gain:_____lbs<br>I ❑ Appropriate ❑ Excessive ❑ Inadequate<br>How do you feel about the weight you have gained so far with this pregnancy?<br><br>What questions do you have about your weight gain during pregnancy? | ❑Discussed plotting and reviewing weight gain at every visit<br>Client agrees to follow STT NUT handout(s) (indicate date):<br>❑ **Tips To Gain Weight** _____<br>❑ **Tips to Slow Weight Gain** _____<br><br>❑ Referred to RD (date): _____<br>❑ Referred to/date: _____<br>❑ Client will: | |
| 2 Current weight gain:<br>❑ Appropriate ❑ Excessive ❑ Inadequate<br>How do you feel about the weight you have gained so far with this pregnancy? | ❑ Referred to RD (date): _____<br>❑ Referred to/date: _____<br>❑ Client will: | |
| 3 Current weight gain:<br>❑ Appropriate ❑ Excessive ❑ Inadequate<br>How do you feel about the weight you have gained so far with this pregnancy? | ❑ Referred to RD (date): _____<br>❑ Referred to/date: _____<br>❑ Client will: | |
| **Biochemical: Lab Values** | | |
| 3. Consult with provider regarding whether there are abnormal lab values and treatment prescribed.<br>I HGB _____ HCT _____<br>Fasting Blood Glucose_____<br>Date of consultation with provider_____<br>Abnormal lab values: ❑ No ❑ Yes, Explain: | If approved by provider, review with client:<br>Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Get the Iron You Need** _____<br>❑ **If You Need Iron Pills** _____<br>❑**Iron Tips**_____❑**Iron Tips: Take Two**_____<br>❑**My Action Plan for Iron**_____<br>❑ **Get the Folic Acid You Need** _____<br>❑**Folic Acid: Every Woman, Every Day**_____<br>❑ **Vitamin B12 is Important**_____<br>❑ Anemia, iron prescribed<br>❑ Referred to RD (date): _____<br>❑ Client will: | |
| 2 Consult with provider regarding whether there are abnormal lab values and treatment prescribed.<br>Fasting Blood Glucose_____<br>Date of consultation with provider: _____<br>Abnormal lab values: ❑ No ❑ Yes, Explain: | ❑ Referred to RD (date): _____<br>❑ Client will:<br>❑ See Question 6 for gestational diabetes interventions. | |
| 3 Consult with provider regarding whether there are abnormal lab values and treatment prescribed.<br>Fasting Blood Glucose_____<br>Date of consultation with provider: _____<br>Abnormal lab values: ❑ No ❑ Yes, Explain: | ❑ Referred to RD (date): _____<br>❑ Client will: | |

Client Identifier

| **Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated) | **Nutrition Individualized Care Goal/plan Developed with Client** | **Com-ment** |
|---|---|---|
| | | |
| **Clinical** | | |
| 4. [I] Blood Pressure_____/_____<br>[2] Blood Pressure_____/_____<br>[3] Blood Pressure_____/_____ | ❑ Provider notified if BP > 120/80<br>❑ Provider notified if BP > 120/80<br>❑ Provider notified if BP > 120/80 | |
| 5. Do you have any of the following possibly nutrition- related discomforts?<br>[I] ❑ nausea ❑ vomiting ❑ leg cramps ❑ gas<br>❑ heartburn ❑ constipation ❑ hemorrhoids<br>❑ swelling of feet or hands ❑ dizziness ❑ diarrhea<br>❑ other:_____<br><br>Do any of these discomforts keep you from eating as you normally would? ❑ No ❑ Yes. Explain:<br><br>[2] Are there any changes to nutrition- related discomforts?<br>❑ No ❑Yes. Explain:<br><br>[3] Are there any changes to nutrition- related discomforts?<br>❑ No ❑Yes. Explain: | ❑ Discussed symptoms with provider Date_____<br><br>❑ Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Nausea: Tips that Help** _____<br>❑ **Nausea: What To Do When You Vomit**____<br>❑ **Nausea: Choose these Foods** _____<br>❑ **Heartburn: What You Can Do** _____<br>❑ **Heartburn: Should You Use** _____<br>❑ **Constipation: What You Can Do**_____<br>❑ **Constipation: Products You Can Use and Cannot Use** _____<br>❑ **Do You Have Trouble with Milk Foods?** _____<br>❑ Client reviewed WIC handout: Feeling Comfortable While Pregnant www.cdph.ca.gov/programs/wicworks/Pages/WICEducationMaterialsWomen.aspx<br>❑ Referred to RD (date): _____<br><br>❑ Discussed symptoms with provider<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will:<br><br>❑ Discussed symptoms with provider<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date):_____<br>❑ Client will: | |

Client Identifier

| **Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated) | **Nutrition Individualized Care Goal/plan Developed with Client** | **Com-ment** |
|---|---|---|
| 6. Do you have any of these nutrition-related health issues?<br>I<br>❑ Under 19 years of age<br>❑ This pregnancy began less than 24 months since a prior birth<br>❑ Currently breastfeeding another child<br>❑ Gastric Surgery<br>❑ Diabetes ❑ Type 1 ❑ Type 2 ❑ Gestational<br>❑ Ever had a baby who weighed less than 5 1/2 pounds<br>❑ Ever had a baby who weighed more than 9 pounds<br>❑ Ever been told any of your unborn babies were not growing well<br>❑ Ever had an eating disorder, such as anorexia, bulimia, disordered eating<br>❑ Other current or previous nutrition related health issues. Explain: | ❑ Discussed risks with provider Date:_____<br>☐ Client agrees to follow STT N handout(s) (indicate date):<br>❑ **MyPlate for Gestational Diabetes** _____<br>❑ **If You Have Diabetes While You Are Pregnant: Questions You May Have** _____<br>❑ **If You Have Diabetes While You Are Pregnant: Relax and Lower Your Stress** _____<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 2 Are there any new nutrition-related health issues?<br>❑ No ❑ Yes. Explain: | ❑ Discussed risks with provider<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 3 Are there any new nutrition-related health issues?<br>❑ No ❑ Yes. Explain: | ❑ Discussed risks with provider<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| **Dietary** | | |
| 7. Are you currently taking any of the following?<br>I<br>Which one? / How much /often?<br>❑ Iron _____ _____<br>❑ Folic Acid _____ _____<br>❑ Prenatal vitamins/minerals _____ _____<br>❑ Other vitamins or mineral _____ _____<br>❑ Home remedies or herbs/teas _____ _____<br>❑ Liquid or powdered supplements _____ _____<br>❑ Laxatives _____ _____<br>❑ Prescription medicines _____ _____<br>❑ Antacids _____ _____<br>❑ Over-the-counter medicines _____ _____ | ❑ Discussed findings with provider, date:_____<br>Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Take Prenatal Vitamins and Minerals**_____<br>❑ **Get the Folic Acid You Need** _____<br>❑ **Get The Iron You Need** _____<br>❑ **If You Need Iron Pills**_____<br>❑**Iron Tips**_____❑**Iron Tips: Take Two**_____<br>❑**My Action Plan for Iron**_____<br>❑ **Get the Folic Acid You Need** _____<br>❑ **Vitamin B12 is Important** _____<br>❑ **Foods Rich in Calcium** _____<br>❑ **You May Need Extra Calcium** _____<br>❑ **Constipation: What You Can Do**_____<br>❑ Referred to RD (date):_____<br>❑ Referred to (profession and date): _____<br>❑ Client will take prenatal vitamins<br>❑ Client will: | |
| 2 Are there any changes to supplements/medications noted above?<br>❑ No ❑ Yes. Explain: | ❑ Discussed all new findings with provider Date:_____<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date):_____<br>❑ Client will take prenatal vitamins<br>❑ Client will: | |
| 3 Are there any changes to supplements/medications noted above?<br>❑ No ❑ Yes. Explain: | ❑ Update: | |

Client Identifier

| **Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated) | **Nutrition Individualized Care Goal/plan Developed with Client** | **Com-ment** |
|---|---|---|
| 8. Have you had any changes in your appetite or eating habits since becoming pregnant? ❑ No ❑ Yes. Explain:<br>I | ❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 2 Have you had any changes in your appetite or eating habits? ❑ No ❑ Yes. Explain: | ❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 3 Have you had any changes in your appetite or eating habits? ❑ No ❑ Yes. Explain: | ❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 9. Do you limit or avoid any food or food groups (such as meat or dairy)? ❑ No ❑ Yes. Explain:<br>I<br>Why do you avoid these foods?<br>❑ Do not like ❑ Allergy ❑ Physician advice<br>❑ Intolerance ❑ Personal Choice<br>❑ Other: _____ | Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Do You Have Trouble with Milk Foods** _____<br>❑ **Foods Rich in Calcium** _____<br>❑ **You May Need Extra Calcium** _____<br>❑ **Vitamin B12 is Important** _____<br>❑ **Get the Folic Acid You Need**_____<br>❑ **Get The Iron You Need** _____<br>❑ **If You Need Iron Pills**_____<br>❑**Iron Tips**_____❑**Iron Tips: Take Two**_____<br>❑**My Action Plan for Iron**_____<br>❑ **When You Are a Vegetarian: What Do You Need To Know** _____<br>❑ **Choose Healthy Foods**_____<br>❑ **MyPlate for Moms/My Nutrition Plan for Moms** _____<br>❑ **MyPlate for Gestational Diabetes** _____<br>❑ Referred to RD (date):_____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 2 Are there any changes to food groups avoided? ❑ No ❑ Yes. Explain: | ❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 3 Are there any changes to food groups avoided? ❑ No ❑ Yes. Explain: | ❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 10. Have you fasted during this pregnancy or do you plan to fast? ❑ No ❑ Yes. Explain how long and how often:<br>I | ❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will: | |
| 2 ❑ No ❑ Yes. Explain how long and how often: | Update: | |
| 3 ❑ No ❑ Yes. Explain how long and how often: | Update: | |
| 11. Do you ever eat any of the following:<br>I<br>❑ Raw or undercooked eggs, meat, shellfish, fish, including sushi<br>❑ Alfalfa/mung bean sprouts<br>❑ Deli meat or hot dogs without heating or steaming<br>❑ Unpasteurized milk, cheese or juice, including soft cheeses such as feta, blue cheese, queso de crema, asadero, queso fresco, panela, or homemade<br>❑ Shark, swordfish, king mackerel, or tilefish<br>❑ Albacore tuna >6 ounces/week ☐ Fish more than 2x/week<br>☐ Locally caught fish more than 1x/week | Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Don't Get Sick From the Foods you Eat**_____<br>❑ **Lower Your Chances of Eating Food with Unsafe Chemicals in Them**_____<br>❑ **Checklist for Food Safety**_____<br>❑ **Tips for Cooking and Storing Food**_____<br>❑ **Tips for Keeping Foods Safe** _____<br>❑ **Eat Fish Safely**_____<br>❑ Referred to RD (date):_____<br>❑ Referred to/date: _____<br>❑ Client will: | |
| 2 Are there any changes to food choices noted above? ❑ No ❑ Yes. Explain: | Update: | |
| 3 Are there any changes to food choices noted above? ❑ No ❑ Yes. Explain: | Update: | |

Client Identifier

| **Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated) | **Nutrition Individualized Care Goal/plan Developed with Client** | **Com-ment** |
|---|---|---|
| 12. Do you eat or have you craved any of the following?<br>[I] ❑ Clay or dirt ❑ Laundry starch ❑ Cornstarch<br>❑ Ice or freezer frost ❑ Plaster or paint chips<br>❑ Other non-food item:_____<br><br>△2 Are there any changes to non-food cravings noted above?<br>❑ No ❑ Yes. Explain:<br><br>△3 Are there any changes to non-food cravings noted above?<br>❑ No ❑ Yes. Explain: | ❑ Client will:<br>❑ Referred to RD (date):_____<br>❑ Referred to/date: _____<br><br>Update:<br><br>Update: | |
| 13. Do you have the following?<br>[I] ❑ Oven ❑ Electricity ❑ Microwave<br>❑ Stove ❑ Refrigerator ❑Clean running water<br>❑ Missing any of the above<br><br>△2 Are there any changes to the responses noted above?<br>❑ No ❑ Yes. Explain:<br><br>△3 Are there any changes to the responses noted above?<br>❑ No ❑ Yes. Explain: | Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Tips for Cooking and Storing Food** _____<br>❑ **When You Cannot Refrigerate, Choose These Foods** _____<br>❑ **Tips for Keeping Food Safe** _____<br>❑ Referred to RD (date):_____<br>❑ Referred to (profession and date): _____<br>❑ Client will:<br><br>Update:<br><br>Update: | |
| 14. In the past month, were you worried that your food would run out before you or your family had money to buy more?<br>[I] ❑ No ❑ Yes. Explain:<br>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? ❑ No ❑ Yes. Explain:<br><br>Do you use any of the following food resources?<br>• WIC: ❑ No ❑Yes WIC Site: _____<br>• CalFresh (food stamps)? ❑ No ❑ Yes<br>• Any free food, such as from food banks, pantries or soup kitchen? ❑ No ❑Yes<br><br>△2 Are there any changes to the food security responses noted above? ❑ No ❑ Yes. Explain:<br><br>△3 Are there any changes to the food security responses noted above? ❑ No ❑ Yes. Explain: | Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Tips For Healthy Food Shopping**_____<br>❑ **You can Buy Healthy Food on a Budget**_____<br>❑ **You Can Stretch Your Dollars: Choose These Easy Meals and Snacks** _____<br><br>❑ Referred client to WIC<br>❑ Referred client to CalFresh (Food Stamps)<br>❑ Referred client to local emergency food resources<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will:<br><br>Update:<br><br>Update: | |
| 15. What kinds of physical activity do you do?_____<br>[I] How often?_____ How long?_____<br><br>On an average day, are you physically active at least 30 minutes each day? ❑Yes ❑ No<br><br>On average day, do you spend over 2 hours watching a screen (TV, computer)? ❑ No ❑ Yes<br><br>Has a doctor told you to limit your activity? ❑ No ❑ Yes<br><br>△2 Are there any changes in your activity described above?<br>❑ No ❑Yes. Explain:<br><br>Are there any changes in your activity described above?<br>△3 ❑ No ❑ Yes. Explain: | ☐ Review activity level with provider.<br>☐ Client agrees to follow STT HE handout(s) (indicate date):<br>❑ **Stay Active When Pregnant** _____<br>❑ **Keep Safe When You Exercise** _____<br>❑ **Exercises to Do When You are Pregnant** _____<br>❑ Client identified ways to be more active each day<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will:<br><br>Update:<br><br>Update: | |

Client Identifier

| **Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated) | **Nutrition Individualized Care Goal/plan Developed with Client** | **Com-ment** |
|---|---|---|
| 16. Complete one of these Nutrition Assessments:<br>❑ 24-hour Perinatal Dietary Recall<br>❑ Perinatal Food Group Recall<br>❑ Approved Food Frequency Questionnaire<br><br>2 Complete Nutrition Assessment<br>❑ 24-hour Perinatal Dietary Recall or<br>❑ Perinatal Food Group Recall<br>❑ Approved Food Frequency<br><br>3 Complete Nutrition Assessment<br>❑ 24-hour Perinatal Dietary Recall or<br>❑ Perinatal Food Group Recall<br>❑ Approved Food Frequency | Client agrees to follow STT N handout(s) (indicate date):<br>❑ **MyPlate for Moms**_____<br>❑ **MyPlate for Gestational Diabetes** _____<br>❑ Referred to RD (date): _____<br>❑ Referred to (profession and date): _____<br>❑ Client will:<br><br>Update:<br><br>Update: | |
| 17. What have you heard about breastfeeding?<br>I _____<br>_____<br>_____<br><br>What do you think about breastfeeding your new baby?<br>❑ Not interested ❑ Thinking about it ❑ Wants to<br>❑ Definitely will ❑ Other_____<br><br>Do you know of the risks of not breastfeeding? ❑ No ❑Yes.<br><br>Is there anything that would prevent you from breastfeeding? ❑ No ❑Yes. Explain:<br><br>Have you ever breastfed or pumped breast milk for your baby?<br>❑ No: Why not? _____<br>❑ Yes. How long?_____<br>What was your previous breastfeeding goal? _____<br>What is your current breastfeeding plan?_____<br>_____<br><br>If you are going to breastfeed, who can you go to for breastfeeding help?_____-_____<br><br>2 What do you think about breastfeeding your new baby?<br>❑ Not interested ❑ Thinking about it ❑ Wants to<br>❑ Definitely will ❑ Other: _____<br><br>What are your new questions about feeding your baby? _<br>_____<br><br>3 How do you plan to feed your baby in the first month of life?<br>Mark all that apply:<br>❑ Human (breast) milk ❑ Formula<br>❑ Other:_____<br><br>What are your new questions about feeding your baby? | Client agrees to follow STT N handout(s) (indicate date):<br>❑ **Nutrition and Breastfeeding – Common Questions and Answers** _____<br>❑ **How Does Formula Compare to Breastmilk**_____<br>❑ **A Guide to Breastfeeding**<br>❑ **My Action Plan for Breastfeeding** _____<br>❑ **My Birth Plan** _____<br>❑ **Breastfeeding Checklist for My Baby and Me** _____<br>❑ **My Breastfeeding Resources**_____<br>❑ **Breastfeeding and Returning to Work or School**____<br>❑ Client received local breastfeeding resources<br>❑ Referred to RD (date): _____<br>❑ Referred to lactation consultant: _____<br>❑ Client will:<br><br>Update:<br><br>Update: | |

Client Identifier

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|---|---|---|
| 18. Do you have any other nutrition questions or concerns?<br>I ❑ No ❑ Yes, describe:<br><br>2 ❑ No ❑ Yes, describe:<br><br>3 ❑ No ❑ Yes, describe:<br>19. | Intervention:<br>Client goal/plan:<br><br>Intervention:<br>Client goal/plan:<br><br>Intervention:<br>Client goal/plan | |
| 20. Discussed the nutrition assessment with client and client identified the following strengths:<br>I<br><br>2<br><br>3 | | |

## Nutrition:

I Minutes spent _____ Completed by: _____ _____ _____
Signature Title Date

Signature of medical provider *if assessor is CPHW*: _____ _____ _____
Signature Title Date

2 Minutes spent _____ Completed by: _____ _____ _____
Signature Title Date

3 Minutes spent _____ Completed by _____ _____ _____
Signature Title Date