Patient Identification

Comprehensive Perinatal Services Program
COMBINED REASSESSMENT &
INDIVIDUALIZED CARE PLAN (ICP) THIRD TRIMESTER

Date:_____/_____/_____ Wks. Gestation:_____

Abbreviations: Ecd--educated Fwd--followed HE--Health Education HO---handout NUTR--Nutrition PSY--Psychosocial STT--Steps to Take
Y--Yes N--No N/A--not apply (Info, F/U, R: See Guidelines)

PSYCHOSOCIAL ASSESSMENT | **ICP Interventions** | Info | F/U | R

1. Do you have any questions/concerns about your..... pregnancy? OY ON Describe:_____
_____
Current pregnancy complications? OY ON
_____
Fears about labor/delivery? OY ON
Fears about infant care/parenting skills? OY ON
_____

1. OEducate to allay fears. .....
OEncourage class attendance-childbirth prep, and infant care/parenting. .....
OEncourage client to discuss concerns re: complications with medical provider. .....
O_____
_____
_____

2. Have there been any changes in your personal life..... since your last interview?
Lifestyle OY ON
Relationship with FOB OY ON
Living accommodations OY ON
Finances OY ON
Emotional support OY ON
Feeling overwhelmed OY ON
Experiencing mood swings OY ON
Other_____
_____

2. OReferral:_____
_____
OFwd STT P 28-34 *Financial Concerns* _____
_____
_____
_____
OCounseling referral:_____
_____
_____
_____

3. Are you working? OY ON..... Attending school? OY ON
Is FOB working? OY ON

3. _____
OFwd STT P 87 *Teen Preg. & Parenting: Educ. Plans* .....
_____

4. How are others in your life adjusting to your ..... pregnancy?
FOB: OPositive ONegative _____
Family: OPositive ONegative _____
Friends: OPositive ONegative _____

4. _____
_____
_____
_____
_____

5. Do you have adequate housing? OY ON..... Transportation OY ON
Adequate finances OY ON
Clothing for yourself &/or children OY ON
Other:_____
_____

5. Housing referral: _____
ODiscussed public transportation. .....
OReferral:_____
_____
_____
_____

6. Are you preparing/prepared for the baby?..... Adequate support system OY ON
Infant clothing and supplies OY ON Crib OY ON
Child care arrangements for siblings OY ON

6. OReviewed clothing/supply needs. .....
OReferral: low cost/used baby items_____
OReferral: free infant clothing_____
OReferral:_____

7. Perinatal substance use? OY ON..... Changes in use? OY ON Describe: _____
_____
Alcohol_____
Street Drugs_____
Tobacco_____
_____
Prescription drugs _____
_____
_____

7. OReferred to Perin. Subst. Abuse Program. .....
OFwd STT HE 87 *Drug & Alcohol Use, The Risks* .....
OFwd STT P 65-68 *Perinatal Substance Abuse* .....
OEcd per STT P HO-G, H ....
OEcd per STT HE HO-R .....
OFwd STT HE 83 *Secondhand Tobacco Smoke* .....
OFwd STT HE 79 *Tobacco Use*.....
OEcd per STT HE HO-Q
OEcd per STT P HO-G
OReassess each visit. .....

8. Are you experiencing threats or abuse from your..... partner? Emotional OY ON Physical OY ON
Sexual OY ON _____
_____
_____

8. OFwd STT P 53-59 .....
OEcd per P HO-E, F .....
OReferral:_____
_____
_____

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Psychosocial Problems/Needs **Plan** (Developed in consultation with the patient.) Info F/U R

NUTRITION ASSESSMENT

9. Any change in your eating habits? ○Y ○N.....
   Do you have enough food to eat? ○Y ○N
   Enrolled in WIC? ○Y ○N ○Declined

10. 24 Hour Diet Recall obtained below. ○Y ○N.....

ICP Interventions

9. ○Referred to food assistance:_____
   ○Referred to WIC:_____
   ○Referred to RD:_____
   ○_____

10. ○Fwd STT N 21-28 *Eating..., Food Intake & Recall* .....
    ○Ecd *Daily Food Guide,* WIC or STT N 28 .....
    ○Ecd_____

24 Hour Diet Recall

Time	Amount	Food & Drink	Fruits & Vegetables A C Other	Breads, Grains, Cereals	Milk	Protein	Fats Other
		Total					
		WIC Recommendations					
		Evaluation					

Comments/Nutrition Goals:

Patient Identificaiton

Info FU R

ICP Interventions

11. Current wt:_____lbs. .....
Wt. goal:_____lbs.
Cumulative wt gain:_____lbs.

11. ○Plotted wt. on grid. ○Counseled on wt. gain/loss
○Fwd STT N 8-14 *STT to Appropriate Wt. Gain* .....
○Ecd STT N HO-A,B1, B2 (as appropriate) .....
○Referral to RD:_____

12. BP_____Change since last visit: ○Higher ○Lower...
Edema ○Y ○N Other:_____

12. ○Notified medical provider. .....
○Reinforced medical recommendations. .....

13. Hgb/Hct: _____Date:_____/_____/_____.....
Abnormal blood/urine test results:_____
_____Date:_____/_____/___
GTT: ○Y ○N Date____/____/____

13. ○Reviewed lab results. .....
○Reinforced medical recommendations. .....
○ Fwd STT N 59-60 *Anemia* .....
○ Ecd STT N HO-L, M, N .....
○Referred to RD:_____

14. Are you taking any of the following?.....
Prenatal vitamins ○Y ○N Iron ○Y ○N
Other vitamins/minerals ○Y ○N
Herbs ○Y ○N _____
New medications ○Y ○N _____

14. _____
_____
_____
_____
_____

15. How do you plan to feed your baby?.....
○Breast
○Bottle
○Both

15. ○Fwd STT HE 99-100 *Infant Feeding Decision-Making* ...
○Fwd STT N 122-131 *Breastfeedin*g .....
○Ecd STT N HO- AA, BB1-2, CC1-2, DD1-2, EE1-2
○Breast anatomy &physiology discussed. .....
○Safe formula preparation and storage discussed. .....
○Safe feeding and burping techniques discussed.

Nutrition Problems/Needs | ***Plan*** (Developed in consultation with the patient.)

_____ | _____
_____ | _____
_____ | _____

HEALTH EDUCATION ASSESSMENT | **ICP Interventions**

16. Have you been scheduled for tests/procedures?.....
○Y ○N _____
Any questions about them? ○Y ○N

16. ○Ecd_____
_____
_____

17. Have you selected a birth control method?
○Y ○N _____

17. ○Fwd STT HE 95-97 *Family Planning Choices* .....
○Ecd _____

18 . Do you have a family planning provider?
○Y ○N_____

18. ○Referral:_____
_____

19. Do you have a doctor/provider for your baby? .....
○Y ○N _____

19. ○Referral:_____
○Procedure for accessing care discussed .....

20. Do you have a car seat for your baby? ○Y ○N.....

20. ○Fwd STT HE 101-102 *Infant Safety and Health* .....
○Rationale discussed/law explained .....
○Plans to purchase/get as gift .....
○Referral:_____

21. Are you getting enough rest? ○Y ○N .....

21. ○Ecd_____

22. Are you exercising regularly? ○Y ○N .....

22. ○Fwd STT HE 69 *Safe Exercising & Lifting* .....
○Ecd STT HE HO-N1-2, O, P .....

23. Are you takings any new medications or herbs?.....
○Y ○N _____

23. ○Ecd_____
_____

24. Have you attended any prenatal classes? ○Y ○N.....

24. ○Referred to classes:_____

25. What would you like to learn about?
○ Breastfeeding.....
○Changes: emotional, physical .....
○Circumcision .....
Common Discomforts:
○Braxton Hicks contractions .....
○Constipation .....

25. ○Fwd STT N 122-131 *Breastfeeding*
○Ecd STT N HO –AA, BB1-2, CC1-2, DD1-2, EE1-2
○Ecd _____
○Ecd _____

○Ecd_____
○Fwd STT N 47 *Constipation* .....
○Ecd STT N HO-H, I .....
○Ecd_____

Patient Identification

Info F/U R

ICP Interventions

○Diarrhea	○Ecd
○Edema	○Ecd
○Fatigue/rest needs	○Ecd
○Frequent urination	○Ecd
○Headaches	○Ecd
○Heartburn	○Fwd STT N 41-42 *Heartburn*
	○Ecd STT N HO-F, G
○Hemorrhoids	○Ecd
○Hormonal effects on gums	○Ecd
○Leg cramps	○Ecd
○Ligament pain/backache	○Ecd
	○Maternity back support
○Varicose veins	○Ecd
○Shortness of breath	○Ecd
○Decreased appetite	○Ecd
○Danger signs/emerg. med. care	○Ecd
○Dental care	○Ecd HE HO-L
○Fetal growth	○Ecd
○Fetal movement pattern	○Ecd
○ Hospital tour	○Ecd
○Kegal exercises	○Ecd STT HE HO-N1
	○Ecd
○Labor & delivery	○Ecd
○Signs of labor	○Ecd
○Fetal monitoring	○Ecd
○Labor process	○Ecd
○Vaginal/VBAC/Cesarean	○Ecd
○Forceps/vacuum extraction	○Ecd
○Episiotomy	○Ecd
○Medication: Pain/anesthesia	○Ecd
○Things to take to the hospital	○Ecd
○When to go to the hospital	○Ecd
Infant Care:	
○Bathing/clothing	○Ecd
○Diaper care/cord care	○Ecd
○Growth/ development (0-3 mo.)	○Ecd
○Oral Health	○Fwd STT HE 59-63 *Oral Health During Infancy*
	○Ecd STT HE HO-M1-2
○Signs of illness/safety	○Fwd STT HE 101-103 *Infant Safety and Health*
	○Ecd STT HE HO-S1-2, T, U,
○Non-stress test	○Ecd
Postpartum expectations:	
○Bonding/Infant feeding	○Ecd
○Breasts, epis./incision care	○Ecd
○Fundal massage/lochia	○Ecd
○Newborn blood screening	○Ecd
Other:	○Ecd

Health Education Problems/Needs	***Plan*** (Developed in consultation with the patient.)

Signature/Title_____Date_____/_____/_____Time in minutes_____

Supervising Physician's Signature_____Date_____/_____/_____