Patient Identification

CPSP INITIAL COMBINED ASSESSMENT &
INDIVIDUALIZED CARE PLAN
(N-P-HE) G:_____P:_____EDC:_____LMP:_____Wks. gestation_____

STRENGTHS: ○Motivated ○Financially stable ○Adequate transportation
○Good support system ○Employed ○High school education
○Emotionally stable ○Adequate food ○Ability to comprehend and make decisions
○Ability to cope ○Refrigerator/stove ○Interest/willingness to participate in individual/group classes
○Previous experience with pregnancy, childbirth & parenting
_____
_____

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

(N-P-HE) PERSONAL INFORMATION

1. Ethnicity:_____Age:_____
2. Which language do you prefer to speak: ○ English ○ Spanish ○ Cambodian ○ Laotian ○ Hmong ○ Other
3. Place of birth: ○ U.S. ○ Outside U.S., country:_____
4. How long have you lived in this area? ○ less than 6 months ○ 7-12 months ○ 1-5 years ○ over 5 years
5. Are you: ○ Married ○ Single ○ Divorced/separated ○ Widowed ○ Live with father of baby ○ Other
6. Who do you live with? Total # of adults in household:____ Total # of children:____ # of your children:____

(Optional) Name_____Relationship_____ Name_____Relationship_____
Name_____Relationship_____ Name_____Relationship_____
Name_____Relationship_____ Name_____Relationship_____
Name_____Relationship_____ Name_____Relationship_____

NUTRITION ASSESSMENT **ICP Interventions** Info F/U R

Anthropometric

7. Ht:_____ …… 7. _____
8. Pregravid Wt:____lbs. ○Under ○WNL ○Overwt. ○Very overwt. …… 8. ○Fwd STT N 3-14 *Weight Gain* .....
Current Wt:_____lbs. Plotted on grid. ○Y ○N ○Ecd STT N HO-A, B ….....
Term Wt. Goal:_____lbs. _____
9. Wt gain in previous pregnancies:_____lbs. ○Unknown ○N/A …… 9. _____
10. Current wt. gain is ○WNL ○Excessive ○Inadequate ……. 10._____

Biochemical

11. Blood: date collected_____Hgb./Hct_____/_____ …….. 11. ○Fwd STT N 59-60 *Anemia* .....
○Ecd STT N HO-L, M, N .....
_____
12. Urine: date collected_____Glu____Ketones____PRO____ …….. 12. _____

Clinical:

13. Indicate if any of the following applies: …… 13. ○Referred to RD ….....
○BP_____ ○Referral:_____
○Age 17 years or less ○ 35 years or older _____
○Anemia ○Fwd STT N 59-60 *Anemia* .....
○Currently breastfeeding ○Ecd STT N HO-L …… ….....
○Dental disease _____
○Diabetes/gestational diabetes ○Referred to Sweet Success by provider. ....
○High parity ○Ecd STT GDM HO-C, D, E …….....
○Hx of low birth weight baby _____
○Multiple gestation _____
○Hx of intrauterine growth retardation _____
○Hypertension _____
○Short pregnancy interval (Date/last birth-OB record) _____
○Other medical/OB problems_____ _____
14. Are you on any special diet: ○Y ○N …… 14. ○Fwd STT N 111-113 *Vegetarian Eating*...
○weight loss ○low salt ○Diabetic ○Ecd STT N HO-Z .....
○low fat/cholesterol ○other:_____ ○Fwd STT GDM 3-10 *Gestational Diabetes*
○vegetarian: milk--dairy--fish--chicken--eggs?_____ ○Ecd_____

Patient Identification

24 Hour Diet Recall

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

Comments/Nutrition Goals:

Dietary

15. 24 Hour Diet Recall obtained above. ○Y ○N ……

16. How is your appetite? _____
_____
Do you have any of these problems?
○nausea ○vomiting ○heartburn
○constipation ○diarrhea ○leg cramps
○other:_____

17. How many cups of the following do you drink in a day? .....
regular coffee____regular tea____ sodas____ milk____water____

18. Are you allergic to any foods? ○Y ○N ……
Do you avoid eating certain foods? ○Y ○N
List foods:_____

19. Have you eaten or had cravings for any of the following: .....
○dirt/clay ○ice (more than 1 cup/day)
○cornstarch ○plaster ○cigarette ashes
○other:_____

20. Have your eating habits changed since you became ….....…
pregnant? ○Y ○N ○Describe:_____
_____

ICP Interventions

15. ○Fwd STT N 21-28 *Eating..., Food Intake & Recall*
○Ecd *Daily Food Guide* WIC or STT N 28 .....
○Ecd N HO-C …….....

16. ○Fwd STT N 31-52 (Common discomforts)….....
○Ecd N HO-D, E *Nausea & Vomiting* .....
○Ecd N HO-F, G *Heartburn* ....….....
○Ecd N HO-H, I *Constipation* .....….....
_____
_____

17. ○Ecd_____
_____

18. ○Fwd STT N 53 *Lactose Intolerance* .....
○Ecd N HO- J, K…….....
○Ecd_____

19. ○Fwd STT N 79-80 *Pica*……. .....….....
○Ecd _____
_____
_____

20. ○Ecd_____
_____
_____

Info F/U R

Patient Identification

	ICP Interventions	Info	F/U	R
21. Do you ever run out of food? ○Y ○N ……..…….. If yes, how often?_____ Enrolled in WIC? ○Y ○N Receive Food Stamps? ○Y ○N	21. ○Fwd STT N 81-82 *Stretching Your Food Dollar*..... ○Ecd N HO-R, S, T ..... ○Referred to WIC. Date_____Site_____ ○Referred to Emergency Food Assistance			
22. Do you have a place to cook and refrigerate food? …… ○Y ○N Describe:_____ _____ _____	22. ○Fwd STT N 91*Cooking and Food Storage* ..... ○Ecd N HO-U,V .....……..... ○Fwd STT N 97-100 *Food Safety* ..……..…..... ○Ecd N HO-W, X, Y ….....			
23. How often do you exercise? _____ Type of exercise:_____ How long? _____ _____	23. ○Fwd STT HE 69 *Safe Exercise and Lifting*... ○Ecd per HE HO-N, O, P……..….....….. _____			
24. How are you going to feed your new baby? …… ○Breastmilk ○Formula ○Both ○Undecided ○Other	24. ○Fwd STT HE 99-100 *Infant Feeding Decision-Making* ○Ecd_____			
25. Have you ever breastfed before? ○Y ○N…….. How long?_____Why stopped? _____	25. ○Fwd STT N 122-131 *Breastfeeding* …..... ○Ecd per N HO- AA, BB1-2, CC1-2, DD1-2, EE1-2 _____			

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

_____

_____

_____

HEALTH EDUCATION ASSESSMENT	**ICP Interventions**			
Language/Education				
26. How many years of education have you completed?_____ School/location?_____	26. ○Ecd_____ _____			
27. Are you currently attending school? ○Y ○N …… Where?_____	27. ○Fwd STT P 87 *Teen Preg. & Parenting, Educ. Plans* _____			
28. Do you plan to attend school after your baby's …… birth? ○Y ○N	28. ○Ecd_____ ○Referral:_____			
29. Which language do you prefer to read? ○English …….. ○Spanish ○Cambodian ○Hmong ○Laotian ○None ○Other:_____	29. ○Fwd STT FS 21-27 *CulturalConsiderations, Cross Cultural Communications, Interpreters, Low Literacy* ○Referral:_____			
30. How do you learn best? ○Reading ○Videos…….. ○Classes/groups ○Individual teaching ○Other:_____	30. _____ _____ _____			
31. Do you have any problems (hearing, seeing or reading)…….. that make it hard for you to learn? ○Y ○N Describe: _____	31. ○Referral:_____ _____ _____			
Transportation				
32. Do you have any trouble attending appointments or ……. classes? ○Y ○N Describe:_____ _____	32. ○HO_____ ○Ecd_____ _____			
33. Will you be able to get a car seat for your new baby …… ○Y ○N Describe:_____	33. ○Fwd STT HE 101-103 *Infant Safety and Health* ..... ○Rationale/Law discussed. ..... ○Referred to car seat safety program			
34. Do you wear a seat belt? ○Y ○N _____ ..…	34. ○Rationale/Law discussed. …….....…...			
Health Practices				
35. Is this your first experience with health care in the U.S. ..... or western medicine? ○Y ○N Explain:_____ _____	35. ○Fwd STT FS 29 *Little Experience w/ West. Hlth. Care* _____			

Patient Identification

ICP Interventions Info F/U R

36. Have you had prior experience with and /or knowledge ……. of pregnancy/postpartum issues?
Prenatal care ○Y ○N Delivery ○Y ○N
PP self-care ○Y ○N Infant care ○Y ○N
Safety/injury prevention ○Y ○N _____
Exposures: cat feces, hot baths, raw foods, Xrays, douches, mercury, pesticides ○Y ○N

36. ○Ecd_____
○HO _____
_____
○Fwd STT HE 41-43 *Workplace and Home Safety*
○Ecd STT HE HO-I …….....
○Fwd STT HE 39-40 *Cautions/Other Concerns*
○Ecd STT HE HO-H, I …… .....

37. Do you have any religious/cultural beliefs (e.g. fasting, ……... blood transfusion, food restrictions) that might affect your pregnancy? ○Y ○N Describe:_____
_____

37. _____
_____
_____
_____

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

38. _____
_____

39. Have you taken any of these during this pregnancy? ……..
○prenatal vitamins/minerals
○other vitamins/minerals (e.g. iron)_____
○antacids (e.g. Tums, Mylanta, Alka Seltzer, Rolaids)
○laxatives (e.g. Metamucil, Ex-Lax, Correctol, Fleet)
○aspirin/ ibuprophen compounds (Advil, Motrin, Alleve)
○herbs: ginseng, ma huang (ephedra), hierba buena (spearmint), manzanilla (chamomile)
○other :_____

39. ○**300 Prenatal vitamins dispensed.**
Date/signature_____
○Prenatal vits: Fwd STT N 71-72 *Pn Vits/min*.....
○Ecd per N HO-O,P …….....
○Fwd STT N 47 *Constipation* …….....
○Ecd per N HO-H, I …….....
○Cautioned against aspirin/ibuprophen use. ….....
○F/U with practitioner. …….....
_____

40. How often do you brush/floss your teeth?_____

40. ○Fwd STT HE 47-52 *Oral Health DuringPregnancy*
○Ecd per HE HO-J, K, L …….....

41. When did you last see a dentist?_____

41. ○Dental Referral:_____

42. What birth control method do you plan to use after this ……. pregnancy?_____

42. ○Fwd STT HE 95-97*Family Planning Choices* .....
○Referral:_____

43. Have you ever had a sexually transmitted infection: ...…… gonorrhea, syphilis, chlamydia, or herpes? □Y □N
If yes, explain:_____

43. ○Fwd STT HE 23-25 *STIs* ……. .....
○Ecd per HE HO-F, H …….....
○Referral:_____

44. Do you know/understand how HIV, the AIDS virus, is …. transmitted? ○Y ○N

44. ○Fwd STT HE 29-33 *HIV and Pregnancy* .....
○Ecd per HE HO-G …….....
○**Ecd on HIV risk factors & pregnancy** .....
○**Testing offered/recommended** …….....

45. What would you like more information about? ……..
○Danger signs
○Preterm labor
○Childbirth prep classes
○Labor & Delivery
○Hospital tour
○Parenting classes
○Newborn care
○Family planning
○Dental care
○Pregnancy changes/fetal growth
○Breastfeeding
○Kick counts
○Cats
○Raw foods
○Hot tubs
○ESL classes
○Other:_____

45. ○Referred to classes. …… .....
○Ecd_____
_____
_____
_____
_____
_____
_____
_____
_____
○HO _____
_____
_____
_____
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_____
_____
_____

46. Do you have someone to assist you during this pregnancy with appointments, classes, L&D, etc.?
○Y ○N_____

46. _____
_____
_____

Patient Identification

H

ealth Education Problems/Needs ***Plan*** (Developed in consultation with the patient.) Info FU R

PSYCHOSOCIAL ASSESSMENT **ICP Intervention**

47. How do you feel about being pregnant? ○Happy ○Sad …….. ○Concerned ○Excited ○Other:_____
48. Is this pregnancy ○Planned ○Wanted …….. ○Unplanned ○Unwanted?
49. Have you been pregnant before? ○Y ○N …….. Experienced pregnancy or child loss? ○Y ○N Number of children living with you:_____
50. Do any of your/your partner's children live with …… someone else? ○Y ○N

Support System

51. Who is going to help you with the pregnancy? ○FOB ……. ○Your/his parents ○Siblings ○Friend ○Other:_____
52. Who do you talk to when you have problems? ○FOB … ○Your/his parents ○Siblings ○Friends ○Other:_____
53. What is your relationship with the father of the baby? …… ○Emotional support ○Financial support ○Not in contact ○Other:_____

Economic Resources

54. What are your sources of income assistance? ……... (Check all that apply) ○TANF ○Self-assistance_____ ○Self---work_____ ○Spouse/FOB---work_____ ○Friends ○Family members ○Other:_____
55. Is there anything at work or home that you worr …….. about because you are pregnant (e.g. lifting heavy objects, chemicals, not enough breaks)? ○Y ○N If yes, describe:_____
56. Do you plan to work after the baby is born? ○Y ○N If yes, how soon after birth?_____
57. Is child care available for your new baby? ○Y ○N ○N/A Who?_____

Stressful Life Event

58. Have you ever received any counseling for emotional problems? ○Y ○N Describe:_____
59. Are you dealing with any of the following? (Check all that apply)
    ○Recent death ○Illness/Injury
    ○Recent immigration ○Separation/Divorce
    ○Unemployment/Homeless ○Legal problems
    ○Child custody issues
    ○Other:_____

47. _____
48. ○Fwd STT P 5-8 *Unwanted Pregnancy* ……..
    ○Ecd per P HO-A,B ……
49. ○Fwd STT P 13-16 *Perinatal Loss* ……
    ○Ecd per P HO-C, D ……
50. ○Fwd STT P 44-48 *Parenting Stress* ……
    ○Fwd STT P 35-37 *Legal Advocacy Concerns* ……
51. _____
52. _____
53. _____
54. ○Fwd STT P 28-34 *Financial Concerns* ……
    ○Referred to Social Services ……
55. ○Fwd STT HE 41-43 *Workplace & Home Safety* ……
    ○Ecd per HE HO-I ……
56. _____
57. ○Referred to child care program : _____
    ○Referral:_____
58. ○Fwd STT P 73-76 *Emotional/Mental Concerns* ……
    ○Fwd STT P 77-81 *Depression* ……
    ○Ecd per P HO-I ……
59. ○Fwd STT P 35-37 *Legal/Advocacy Concerns* ……
    ○Fwd STT P 38-43 *New Immigrant* ……

Patient Identification

ICP Interventions Info F/U R

60. Do you have any of the following? (Check all that apply) ……
○Experiencing mood swings
○Having problems sleeping
○Feeling anxious/nervous
○Feeling sad, depressed
○Feeling like there is no hope in your life
○Feeling lonely, no one understands you
○Thoughts of hurting self, unborn baby, or others
○Other:_____

60. ○Referral:_____
○Ecd_____
_____
○Referral:_____
_____
_____
_____
_____
_____

61. As a child or as an adult, have you ever been abused …….. physically, sexually or emotionally? ○Y ○N If yes, explain:_____

61. ○Fwd STT P 49-52 *Child Abuse & Neglect* .....
○Referral given:_____
_____

62. Are you in a relationship in which you have been …….. physically hurt or threatened by your partner? ○Y ○N Explain:_____

62. ○Fwd STT P 53-58 *Spousal/Partner Abuse* .....
○Ecd per P HO-E, F …….....…....
○Referral:_____

63. Where do you currently live? ○Room ○Apartment …. ○House ○Group Home ○Other:_____

63. ○Referred to housing resource: _____
_____

64. Do you feel safe where you live? ○Y ○N If no, explain:
_____
_____

64. _____
_____
_____

Substance Use

65. Have you ever smoked: ○N ○Y drunk alcohol: ○N ○Y used street drugs: ○N ○Y (Name drug/s, when)_____
_____

65. _____
_____
_____

66. Since the start of this pregnancy have you used the following?
Tobacco: ○N ○Y Last use?_____How much?_____
_____
Alcohol: ○N ○Y Last use?_____How much?_____
_____
Street drugs: ○N ○Y Last use?_____How much?_____
_____
_____

66. ○Fwd STT P 65-68 *Perinatal Subst. Abuse* .....….
○Fwd STT HE 87-91 *Drug & Alcohol Use* .....….....
○Ecd per HE HO-R .....….....
○Ecd STT P HO-G, H .....….....
○Fwd STT HE 79-82 *Tobacco Use* .....….....
○Ecd per HE HO-Q …….....….....
○Refer to Perinatal Subst. Abuse Program_____
_____

67. Are you around people who smoke? ○Y ○N If yes, ... describe:_____
_____

67. ○Fwd STT HE 83 *Secondhand Tobacco Smoke* …....
○Negotiation skills discussed .....
○Encouraged smoke-free zone.....

Pregnancy Concerns

68. Do you have any concerns about having a baby? (e.g. L&D, infant care, etc.) ○Y ○N Explain:_____
_____

68. ○Referral:_____
_____
_____

69. What are your goals/hopes for this pregnancy?_____
_____

69. _____
_____
_____

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

_____

_____

_____

Signature/title:_____Title:_____Date:_____/_____/_____Time in minutes:_____

Signature of supervising physician:_____Date:____/_____/_____