STATE OF NEW JERSEY
PERINATAL RISK ASSESSMENT
Third Trimester Form

ALL FIELDS REQUIRED

PLEASE PRINT CLEARLY

42628

Date Form Completed M M - D D - Y Y

Medicaid ID

Insurance ID

Insurance Effective Date M M - D D - Y Y

Provider Information

NPI Group NPI

Patient Information

Name _____ Date of Birth _____

Address _____ Primary Phone _____

_____ Provider Chart # _____

County _____

New Information

Name _____

Address _____

_____ County _____

Primary Phone _____ Preferred Contact ○ Call ○ Text

Prenatal Care

Planned Delivery Site Code

# of prenatal care visits

Date of last prenatal care visit M M - D D - Y Y

EDD M M - D D - Y Y

Current Pregnancy Risk Factors

	Yes	No	Unk		Yes	No	Unk
Toxoplasmosis	○	○	○	CMV	○	○	○
Listeria	○	○	○	HPV	○	○	○
Influenza	○	○	○	Chlamydia	○	○	○
Varicella Zoster	○	○	○	Syphilis	○	○	○
Parvovirus	○	○	○	Gonorrhea	○	○	○
West Nile Virus	○	○	○	Group B Strep	○	○	○
Rubella	○	○	○	Trauma	○	○	○
Lyme Disease	○	○	○	Rh Sensitization	○	○	○
Malaria	○	○	○				

	Yes	No		Yes	No
Hyperemesis	○	○	Maternal Fetal Infection	○	○
Obesity	○	○	Abdominal Surgery	○	○
Gestational Diabetes	○	○	Fetal Genetic/Structural Abnorm	○	○
Insulin Dependent	○	○	Pyelonephritis	○	○
PIH/Preeclampsia	○	○	Urinary Tract Infection	○	○
Eclampsia	○	○	Hepatitis A	○	○
Placenta Previa	○	○	Hepatitis B	○	○
Cervical Incompetence	○	○	Hepatitis C	○	○
Multiple Gestation	○	○	Alcohol Use	○	○
Macrosomia	○	○	Illicit Drug Use	○	○
IUGR	○	○	Opiate Dependency	○	○
Oligo/Polyhydramnios	○	○	Opioid Replacement Tx	○	○
Abnormal Amniocentesis	○	○	Rh Negative	○	○
Abnormal AFP	○	○			

Current Medical Conditions/Risks

	Yes	No	Unk	On Meds		Yes	No	Unk	On Meds		Yes	No	Unk	On Meds		Yes	No	Unk	On Meds
Neurological Condition	○	○	○	○	Phlebitis/DVT	○	○	○	○	Liver Disease	○	○	○	○	STD	○	○	○	○
Seizures	○	○	○	○	Anemia	○	○	○	○	Renal Disease	○	○	○	○	HIV	○	○	○	○
Epilepsy/Seizure Disorder	○	○	○	○	Blood Dyscrasia	○	○	○	○	Lupus	○	○	○	na	AIDS	○	○	○	○
Depression/Mental Illness	○	○	○	○	Thyroid Disease	○	○	○	○	Uterine Abnormalities	○	○	○	na					
Asthma	○	○	○	○	Sickle Cell Trait	○	○	○	na	Abnormal Pap Smear	○	○	○	○					
Tuberculosis	○	○	○	○	Thalassemia	○	○	○	○	Allergies	○	○	○	○					
Heart Condition	○	○	○	○															

Fever ≥100.4 more than 24 hours
○ 1st Trimester ○ None
○ 2nd Trimester ○ Unknown
○ 3rd Trimester

Current Psychosocial Risk Factors

	Yes	No		Yes	No
Disabled	○	○	Perinatal Depression	○	○
Homeless	○	○	Domestic Violence	○	○
Unstable Housing	○	○	Education <12 Years	○	○
Transportation Problems	○	○	Unemployed/Inadequate Income	○	○
Eating Disorder	○	○	Husband/Partner Unemployed	○	○
Nutritional Concerns	○	○	Inadequate Social Support	○	○
			Currently in Foster Care	○	○

Child(ren) diagnosed with an Autism Spectrum Disorder?
○ Yes ○ No
○ Unknown ○ N/A

Family History of Congenital Anomalies or Syndromes
○ Yes ○ No
○ Unknown ○ N/A

Prenatal Vitamins

○ 1st Trimester ○ None
○ 2nd Trimester ○ Unknown
○ 3rd Trimester

Blood Type

○ A ○ AB ○ Negative
○ B ○ O ○ Positive

Prenatal Fetal Diagnoses

Select all that apply

○ Coarctation of the Aorta	○ Double Outlet Right Ventricle	○ Tricuspid Atresia	○ Transp of Great Arteries	○ Interrupted Aortic Arch	○ Tetralogy of Fallot
○ Total Anomalous Pulmonary Venous Return	○ Ebstein Anomaly	○ Hypoplastic Left Heart	○ Truncus Arteriosus	○ Pulmonary Atresia	○ None of the above
○ Other Cardiac Anomaly *Specify* _____		○ Other Non-Cardiac Anomaly *Specify* _____		○ Single Ventricle	○ Unknown

PRA ID

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Patient Name

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HIV Was mother known HIV positive entering prenatal care? *If Yes, Skip to Prenatal Procedures* ○ Yes ○ No

Was mother counseled regarding the benefits of HIV testing during the pregnancy? ○ Yes ○ No
If Yes, when? ○ 1st Trimester ○ 2nd Trimester ○ 3rd Trimester
If Yes, where? ○ Provider Office ○ Hospital Labor/Delivery

1st Trimester HIV Specimen Information

HIV testing obtained upon receipt of prenatal care? ○ Yes ○ No ○ Refused Date Specimen Obtained M M – D D – Y Y

Where? ○ Prenatal Provider ○ HIV Provider ○ Hospital Labor/Delivery ○ None ○ Other *Specify* _____

3rd Trimester HIV Specimen Information

HIV testing obtained during 3rd trimester of pregnancy? ○ Yes ○ No ○ Refused Date Specimen Obtained M M – D D – Y Y

Where? ○ Prenatal Provider ○ HIV Provider ○ Hospital Labor/Delivery ○ None ○ Other *Specify* _____

Source of HIV Information

Source of HIV related Information *Select all that apply* ○ Mother's Medical Records ○ Patient's Verbal History ○ Medical Provider Interview ○ None

Hepatitis B Serology Obtained? ○ Yes ○ No ○ Unknown Date of HBSAg Test M M – D D – Y Y

Hepatitis B Surface Antigen Positive? (HBSAg) ○ Yes ○ No ○ Unknown

Syphilis Serology Obtained? ○ Yes ○ No ○ Unknown

If Yes, Date Syphilis Serology Obtained? M M – D D – Y Y

Prenatal Procedures *Select all that apply*

○ Tocolysis	○ Cervical Cerclage	○ External Cephalic Version Attempted
○ CVS	○ Amnio Genetic Screening	○ Successful
○ Selective Fetal Reduction	○ Amnio Assess Lung Maturity	○ Failed
○ Cell Free DNA Test	○ Amnio Other Purpose	○ None of these procedures performed

Fetal Ultrasound Performed Yes ○ No ○
If Yes, When?
○ 1st Trimester
○ 2nd Trimester
○ 3rd Trimester
Number of Ultrasounds

Smoking/Tobacco Use

○ Non Smoker
If Non Smoker skip to 4Ps Plus

How many cigarettes OR packs did you smoke per day during each of the following time periods? *If none during any time period enter zero (0)*

1st Trimester	Cigarettes	OR Packs	2nd Trimester	Cigarettes	OR Packs	3rd Trimester	Cigarettes	OR Packs

4Ps Plus

	Yes	No
Did either of your parents have a problem with drugs or alcohol	○	○
Does your partner have any problem with drugs or alcohol	○	○
Have you ever felt manipulated by your partner	○	○
Have you ever felt out of control or helpless	○	○
Over the past 2 weeks		
Have you felt down, depressed or hopeless	○	○
Have you felt little interest or pleasure in doing things	○	○

	Yes	No
Have you ever drunk beer/wine/liquor	○	○

In the month before you knew you were pregnant	*Any	None
How many cigarettes did you smoke	○	○
How much beer/wine/liquor did you drink	○	○
How much marijuana did you use	○	○

If Any is checked, continue with the 4Ps Follow-Up Questions.

4Ps Plus Follow-up Questions (if *Any above was checked)

In the month before you knew you were pregnant:	Refer for Assessment Every Day	Refer for Assessment 3-6 Days/Wk	Prevention Education 1-2 Days/Wk	Prevention Education <1 Day/Wk	No Referral Needed Did Not Drink/Use Drugs
About how many days a week *did you* usually drink beer/wine/liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○
And now, about how many days a week *do you* usually drink beer/wine/liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○

Referrals/Education

	Referred	Receiving Services	Referral Needed	Refused	Not Needed		Referred	Receiving Services	Referral Needed	Refused	Not Needed
Tobacco Cessation	○	○	○	○	○	Childbirth Education	○	○	○	○	○
Substance Abuse Prevention Ed	○	○	○	○	○	Breastfeeding Consult	○	○	○	○	○
Substance Abuse Assessment	○	○	○	○	○	Emergency Assistance	○	○	○	○	○
Mental Health Assessment	○	○	○	○	○	TANF/GA	○	○	○	○	○
Domestic Violence Assessment	○	○	○	○	○	WIC	○	○	○	○	○
Diabetes Care Program	○	○	○	○	○	SSI	○	○	○	○	○
Preterm Labor Prevention	○	○	○	○	○	DCP&P	○	○	○	○	○
Nutritional Consult	○	○	○	○	○	Food Stamps	○	○	○	○	○
Community Based Services*	○	na	na	○	○	Dental Referral	○	○	○	○	○

** Includes referrals to local Community Health Worker, Community Home Visiting and other supportive services*

Medications/Comments

PRA ID

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