

# **PRA | SPECT**

**PERINATAL RISK ASSESSMENT | SINGLE POINT OF ENTRY  
CLIENT TRACKING SYSTEM**

**WWW.PRASPECT.ORG**

**Community Health Worker  
Staff Level**

**Family Health Initiatives  
2500 McClellan Ave, Suite 270  
Pennsauken, NJ 08109  
856.665.6000**

Rev 063014



# Table of Contents

PRA SPECT System – About .....	4
SPECT Home Page .....	5
Log In To SPECT .....	6
SPECT User Registration Form .....	7
Outreach Events.....	8-10
Adding Outreach Events .....	9-10
Adding Initial Contacts and New Referrals .....	11-14
Duplicate Referrals.....	15
Patient Profile .....	16-17
Community Health Screen .....	18-26
Completing the Community Health Screen .....	19-26
Newly Assigned Patients List .....	27-28
E-mail alert .....	28
Enrolled Patients List .....	29
Closed Patients List .....	30
Adding Engagements/Encounters, Resources, Referrals, and Appointments .....	31-47
Add Engagements/Encounters (Client Contacts) .....	32
Resources, Referrals, and Appointments .....	33-34
Service Type and Service Provider Information.....	35-37
Add Resource .....	38
Status and Outcome Information .....	39-40
Add Referral .....	41-42
Add Appointment .....	43-44
Outcomes for Resources, Referrals, and Appointments .....	45-46
Deleting Incorrect Resources, Referrals, and Appointments .....	47
Forms .....	48-49
Printing Forms.....	49
Notes .....	50

# PRA | SPECT SYSTEM

**The Perinatal Risk Assessment (PRA) tool is used to refer pregnant and postpartum women to Central Intake, Community Home Visiting, and Community Health Worker Services through a Single Point of Entry and Client Tracking (SPECT) System**

4

## **The PRA is:**

- Completed by prenatal care providers in New Jersey
- A uniform assessment tool to determine the risk factors affecting a current pregnancy
- Submitted to Family Health Initiatives (FHI) for data processing
- Used by Medicaid Managed Care Organizations (MMCOs) for case management and as authorization for payment
- Forwarded to Community Home Visiting (CHV) and Community Health Worker (CHW) partner agencies when referral for these programs is necessary and desired by the patient

## **The PRA | SPECT System:**

- Receives client information and automatically forwards referrals received from prenatal providers, social service agencies, and other community partners to the appropriate Central Intake Agency (CI)
- Triage referrals according to criteria determined by the partners
- Alerts the Community Home Visiting or Community Health Workers partner agency of the referral via email
- Provides participating agencies and referring providers with a web portal to identify individuals involved in partnering programs
- Assures secure HIPAA compliant storage and transmission of data
- Reports summary data to participating providers and agencies

## **Referring Prenatal Care Providers:**

- Completes the PRA on ALL pregnant women entering care
- Documents the referral to Central Intake, Community Home Visiting or Community Health Worker in the “Plan of Care” section of the PRA

## **Central Intake Agency:**

- Maintains the PRA | SPECT data system and coordinates the PRA | SPECT partnerships
- Determines and agrees upon criteria for triage of community referrals
- Initiates signed agreements to share information about clients in the system with all partner agencies (referring and receiving)
- Agrees to use the PRA, One Page Referral Form or the Community Health Screen as a uniform referral tool which is completed by referring agencies

## **Community Agencies:**

- Notifies referring agencies about client assignments and enter regular updates about client encounters, resources provided, and referrals and appointments made into PRA | SPECT
- Are responsible for closing cases in the PRA | SPECT system.
- Documents all Encounters with clients up to enrollment and once they are closed.

## **Referral Sources:**

- ❑ PRA (Perinatal Risk Assessment) Forms completed by prenatal care providers
- ❑ Community Health Screening Referral Form completed and faxed or entered online by partnering social service/community agencies/CHW programs or Central Intake
- ❑ Direct from partnering social service/community agencies
- ❑ Staff Outreach
- ❑ Self-referrals

# SPECT Home Page

5

Before contacting FHI, check the Home Page for Frequently Asked Questions, User Manuals, Updates, and New information.

## WWW.PRASPECT.ORG

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

user  password    
[Forgot your password?](#)

- Home
- Registration
- ▼ Documents
  - About PRA|SPECT
  - ▶ Prenatal Care Providers
    - ▼ CI, CHV, & IPO/CHW
      - Frequently Asked Questions
      - Central Intake -
      - Program Supervisor Level Users Manual
      - Central Intake - HUB
      - Administrator-"Unassigned Referral" Grid Instructions
      - Central Intake -
      - Managing MIHOPE Study Clients
      - Recording, Tracking, and Updating
      - Resources Provided, Referrals Given, and Appts. Made - June 2014
      - CHV and CHW
      - Programs Training Schedule July/August 2014
      - CHV and CHW
      - Programs Training Schedule June 2014
      - Request Username and Password

**Click Documents to view the drop down lists.**

- New providers and new PRA website users: A brief training is strongly recommended before you begin using the system. Contact FHI to arrange training for your practice site.
- Click on Documents > Prenatal Care Providers > Users Manual - Prenatal Care Providers for the Users Manual -

**Click to view FAQ's.**

- Click on Documents > Prenatal Care Providers > Hospital Delivery Site Codes - updated 03/05/2014.

**Central Intake, Community Home Visiting, and IPO/CHW Programs:**

- Training is required for ALL new users. To view training schedules: Click on Documents > CI, CHV, & IPO/CHW > Schedules for June and July/August are posted. Be sure to register ahead of time.

If you have questions, need assistance, or to report technical difficulties, please contact FHI:

- Email: [PRA@snjpc.org](mailto:PRA@snjpc.org)
- Phone: 856.665.6000

This system uses files in Adobe Acrobat Portable Document Format (PDF). To view or print these files you must have Adobe Acrobat Reader software installed. Download the latest version FREE at [http://www.adobe.com/acrobat/readstep2.html](#)

**Click to view schedule and register for Training.**

**Click to register a new user.**

COMMUNICATING WITH FHI  
FHI Staff are available during business hours to answer questions and address problems  
Email  
[PRA@snjpc.org](mailto:PRA@snjpc.org)

To report issues, ask questions, clarify policy, and to request users, new programs, and new referring agency partners:

**Email: [SPECT@snjpc.org](mailto:SPECT@snjpc.org)**

# Login to PRA | SPECT

6

## [www.praspect.org](http://www.praspect.org)

### All users must attend mandatory training prior to using the SPECT system

- Current training schedule is available on the landing page prior to logging on.
  - Click **Documents**
  - Click **CI, CHV, & IPO/CHW** OR Contact your Central Intake HUB Administrator or FHI for a schedule.
- The SPECT User Registration form and training must be completed prior to receiving your login information.
  - User Registration form is available on the landing page prior to logging on.
    - Click **Documents**
    - Click **CI, CHV & IPO/CHW**
    - Click **Request Username and Password**

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home
- Registration
- ▶ Documents

**COMMUNICATING WITH FHI**  
FHI Staff are available during business hours to answer questions and address problems

**Email**  
[PRA@snjpc.org](mailto:PRA@snjpc.org)

**Phone**  
856.665.6000

**Business Hours**  
9am - 5pm Monday-Friday

user  password

[Forgot your password?](#)

**Welcome to PRA|SPECT!**

For User's Manuals, please click on "Documents" or contact FHI.

If you have any questions, need assistance, or to report technical difficulties, please contact FHI:

- Email: [PRA@snjpc.org](mailto:PRA@snjpc.org)
- Phone: 856.665.6000

This system uses files in Adobe Acrobat Portable Document Format (PDF). To view or print these files you must have Adobe Acrobat Reader software installed. Download the latest version FREE at

# User Registration Form

7

**PRA|SPECT**

Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

## DATABASE USER REGISTRATION FORM (Please Print Clearly)

Name \_\_\_\_\_  
Title \_\_\_\_\_  
Agency \_\_\_\_\_  
Agency Address \_\_\_\_\_  
Program Name (HF, NFP, PAT, IPO, etc.) \_\_\_\_\_  
County of Program \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_

User name \_\_\_\_\_  
Password (8 characters-alpha numeric) \_\_\_\_\_

### FOR WHICH PROGRAMS DO YOU NEED ACCESS:

- PRA COMPLETION (PRENATAL CARE PROVIDERS)
- CENTRAL INTAKE/ COMMUNITY HOME VISITING
- IMPROVING PREGNANCY OUTCOMES/COMMUNITY HEALTH WORKERS
- OTHER \_\_\_\_\_

### FOR COMMUNITY HOME VISITING, PLEASE INDICATE YOUR ROLE(S):

- Central Intake Administrator
- Program Supervisor / Program Administrator / Data Entry for Program
- Program Staff (Nurse, FSW, PE, Case Mgr, etc.)

### FOR IPO / CHW, PLEASE INDICATE YOUR ROLE(S):

- Program Supervisor / Program Administrator / Data Entry for Program
- Community Health Worker



Please complete and fax to Donna Bordner, FHI, 856-665-7711 or email to [dbordner@snjpc.org](mailto:dbordner@snjpc.org)

# Outreach Events

8

Always add your outreach events in order to attach each initial client contact record to that event.

**Types of Events include:**

- Education
  - Health Education
  - Workshop
  - Other
- Meetings
  - Advisory Board Meeting
  - Informal Meeting
- Outreach
  - Community Event
  - Door-to-Door
  - General Public Event
  - Health Fair
  - Healthcare Setting
  - Public Setting
  - Workshop
  - Other





# Adding Outreach Events

9

- Complete this form with Event Names that are meaningful to your program.
- All fields should be completed.
- **All fields marked with an \* are mandatory.**

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home
- ▶ User Administration
- ▶ CHW Training
- Logoff

### Outreach Events: Add an event

Event Name*	Training Health Fair
Event Date*	06/10/2014
Event Type*	<div style="border: 1px solid black; padding: 2px;"><p>-Select Type-</p><p><b>Education</b></p><p>Health Education Workshop Other</p><p><b>Meetings</b></p><p>Advisory Board Meeting Informal Meeting</p><p><b>Outreach</b></p><p>Community Event Daily Street Outreach Door-to-Door General Public Event Health Fair Healthcare Setting Public Setting Workshop Other</p></div>
Target Audience	
Event Topic(s)	
Event Location	
Contact Person	
Contact Email Address	
Event Notes / Comments	
Display Menu Option	Yes (Toggles display in Initial Contact Form Menu)

#### Event Attendees Totals

Age	Race	Ethnicity	Gender	Outreach
<input type="checkbox"/> Under 10	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Male	<input type="checkbox"/> Initial/Screen
<input type="checkbox"/> 10-14	<input type="checkbox"/> Black		<input type="checkbox"/> Female	<input type="checkbox"/> Total Attend
<input type="checkbox"/> 15-17	<input type="checkbox"/> Multi-Racial			
<input type="checkbox"/> 18-19	<input type="checkbox"/> Asian			
<input type="checkbox"/> 20-21	<input type="checkbox"/> Native American			
<input type="checkbox"/> 22-25	<input type="checkbox"/> Pac Island / Alaskan			
<input type="checkbox"/> 26-34	<input type="checkbox"/> Other			
<input type="checkbox"/> 35-40				
<input type="checkbox"/> 41-45				
<input type="checkbox"/> Over 45				

© 2014 PRA | SPECT

# Outreach Events

The Event you have added is now available to be updated with attendees by clicking on the event date.

- Always update events with attendee totals and contact counts.
  - For numbers to count in IPO/CHW statistic reports, an initial contact record must be attached to an outreach event.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

Outreach Event was successfully processed.

**Outreach Events: Basic Search**  
You are viewing Basic Search Results; the last 25 outreach events. To access additional search options, select [Advanced Search](#)

Event Date	Event Name	Event Type	Displayed in Menu	Total Attend
<b>Education</b>				
05/02/14	dskjf	Heath Education	Yes	N/A
04/03/14	Thursday training	Heath Education	Yes	9
03/31/14	Test Event	Workshop	Yes	N/A
03/08/14	Other	Other	Yes	23
<b>Meetings</b>				
03/06/14	Informal Meeting	Informal Meeting	No	23
<b>Outreach</b>				
06/12/14	Daily Street Outreach	Door-to-Door	Yes	N/A
06/11/14	Wednesday Training Health Fair	Health Fair	Yes	N/A
06/11/14	Dental Health Fair	Health Fair	Yes	50
06/10/14	Training Health Fair	Health Fair	Yes	63
06/10/14	Training Health Fair	Health Fair	No	63
06/10/14	Outreach at Training Hospital	Healthcare Setting	Yes	N/A
05/17/14	Community meeting	Community Event	Yes	50
04/29/14	Tuesday Rainy Day Fair			
04/22/14	Earth Day Festival			
04/17/14	Thursday Health Fair			
04/16/14	Wednesday Health Fair			
04/13/14	Sunday Day Health Fair			
04/09/14	Health Fair at the Park			
04/08/14	Health Fair For Moms			
04/07/14	Health Fair - at Park Willis			
03/07/14	Public Setting			
02/01/14	Brenda's Hair Emporium			
02/28/14	Soucies Nail Shop			
02/22/14	HealthFair for Women			
04/05/13	SNUPC Luau			

**CHW Participant Intake**

Outreach Event:  Referral Date\*:

**Participant Information**

Last Name\*:

---

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**Outreach Events: Add an event**

Event Name\*:

Event Date\*:

Event Type\*:

Target Audience:

Event Topic(s):

Event Location:

Contact Person:

Contact Email Address:

Event Notes / Comments:

Display Menu Option:  Yes (Toggles display in Initial Contact Form Menu)

**Event Attendees Totals**

Age	Race	Ethnicity	Gender	Outreach
<input type="checkbox"/> Under 10	8 White	43 Hispanic	29 Male	25 Initial/Screen
<input type="checkbox"/> 10-14	15 Black		59 Female	63 Total Attend
<input type="checkbox"/> 15-17	5 Multi-Racial			
<input type="checkbox"/> 18-19	Asian			
<input type="checkbox"/> 20-21	Native American			
<input type="checkbox"/> 22-25	Pac Island / Alaskan			
<input type="checkbox"/> 26-34	35 Other			
<input type="checkbox"/> 35-40				
<input type="checkbox"/> 41-45				
<input type="checkbox"/> Over 45				

Initial/Screen is the number of forms completed.  
Total Attend is the number of people that attended this event.

Cancel Submit

# Adding Initial Contacts and New Referrals

11

- Initial Contacts and New client referrals are obtained from the following sources:

- Partner Agencies
- Outreach in the community
- Events and Workshops in the community
- Door to Door outreach
- Self Referrals
- Other Sources

# New Initial Contacts and Referrals

12

From CHW Menu

- Select **CHW** (your agency here)
- Select **Initial Contact**
- Select **Add New Referral**
  - Click **Initial Contact**
  - Click **Add New Referral**.
  - Complete each field of the form. – see *next page*
  - All required fields marked with an \* **MUST** be entered in order to process the form.
  - Click **Save** - to save the form.

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home
- ▶ User Administration
- ▼ CHW Training
  - ▼ Initial Contact
    - Add New Referral
    - Search Modify
  - ▶ Patients
  - ▶ Forms
  - ▶ IPO Administration
- Logoff

Welcome, Isaac

© 2014 PRA | SPECT

# New Initial Contacts and Referrals

13

**All required fields must be entered to submit the form.**

**CHW Participant Intake**

Outreach Event: 06/10/2014: Training Health Fair | Referral Date: 06/10/2014 | Pregnancy Test Date: [ ] | Positive: -Select-

**Participant Information**

Last Name: Perfect | First Name: Percy  
 Street Address: 1 Main St | Apt/Suite/Fl: [ ]  
 City: Camden | Zip: 98765 | County: Camden

\*DOB: [ ] | Participant ID: [ ]

**Referral Agency Information**

\*Referring Agency: System Training Institute | Referrer Last Name: Turner | Referrer First Name: Tina  
 Referrer Title: [ ] | Agency Phone: 999-999-9999  
 Outreach Type:  Agency  Self  Door to Door  Event  Other

\*Participant is....

Preconceptional Woman |  Pregnant Woman |  Interconceptional Woman |  Male

Has no children and has never been pregnant  
 \*First Time Parent:  Yes  No  
 \*In Prenatal Care:  Yes  No  
 \*Due Date: 10/09/2014  
 \*Ages of Child/ren in need of service: [ ] None  
 1. [ ] 2. [ ] 3. [ ]  
 \*Are you a parent?:  Yes  No  
 \*First Time Parent?:  Yes  No  
 \*Child/ren live with you?:  Yes  No

**Participant Contact Information**

\*Primary Phone: 888-888-8888 | \*Preferred Contact Method?:  Primary Phone  Alternate Phone  Email  Text  
 Alt Phone: [ ] | \*At which number can we text?:  Primary  Alternate  None  
 Email: [ ]

**Household Information**

Children in Household? [ ] 0-30d [ ] 0-8y [ ] 1-12m [ ] 9-14y [ ] 1-2y [ ] 15-17y [ ] 3-5y [ ] 10-12y

**Additional Participant Information**

\*Primary Language: English | \*Ethnicity:  Hispanic  No | \*Race: Multi-Racial  
 \*Insurance:  Medicaid  Medicare  NJ Family Care  Commercial  None

**Did you or a family member have any of these issues when you tried to get healthcare in the past?**

No insurance for myself |  No insurance for my children |  No money for co-pays |  Could not find a doctor |  Could not get an appointment |  Did not think going to the doctor was important  
 No transportation |  No childcare |  Could not miss work |  No time |  Staff was rude |  Other: [ ]

**Participant Notes (External)**

Notes: Client legally blind.

**Participant Notes (Internal)**

Notes: [ ]

\*Participant Consent  
 I agree to provide the information above and to have it forwarded as a referral to available service agencies in my community. I agree to be contacted, and for Improving Pregnancy Outcomes staff to follow-up with me or the agency to which I was referred to support my care.  
 No Consent  
 Yes, Oral Consent  
 Yes, Written Consent

**Save**

# New Initial Contacts and Referrals

14

Once the form has been submitted, if it is not a duplicate referral, a message will appear that this patient is new to the system.

- Click **Access the Patient Profile**
  - **To complete the Community Health Screen**
  - **Add Client contact**
  - **Make and track resources, referrals or appointments**
- **Or** you may continue to add new referrals by repeating the **Add New Referral** process.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home
- ▶ User Administration
- ▶ CHW Training
- Logoff

Patient	Percy Perfect
Address	1 Main St
City, State Zip	Camden, NJ 98765
DOB	03/30/1991
Referred Patient	pregnantClient

This patient is new to the system, no prior assessments or referrals have been submitted.

The following options are available for this patient when you [Access the Patient Profile](#)

- Complete the IPO Community Referral Form
- Add Client Contact Information
- Make and Track Referrals and Appointments

© 2014 PRA | SPECT

# Duplicate Referrals

15

- Coming Soon.

# Patient Profile

16

CHW can still access a client record after submitting a form to Central Intake.  
From **CHW** Menu

- Select **Initial Contact**
- Select **Search Modify**
  - **The 25 most recent incomplete screenings will appear.**
  - Click the date of the client record **OR**
  - Click **Advanced Search** to search for all records.
  - Click the clients name from the results list to access the Patient Profile.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home  
▶ User Administration  
▼ CHW Training  
▼ Initial Contact  
• Add New Referral  
• **Search Modify**  
▶ Patients  
▶ Forms  
▶ IPO Administration  
• Logoff

**IPO Initial Contact: Basic Search**  
You are viewing Basic Search Results; the last 25 Initial Contacts in need of screening. To access additional search options, select [Advanced Search](#)

Contact Date	Client Name	CHW	Status
Daily Street Outreach			
<a href="#">06/12/2014</a>	Special Lady	Isaac Pool	Screening Incomplete
Public Setting			
<a href="#">02/04/2014</a>	James Kelly	Isaac Pool	Screening Incomplete
SNJPC Luau			

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home  
▶ User Administration  
▶ CHW Training  
• Logoff

**IPO Initial Contact: Advanced Search**  
To view Basic Search Results; the last 25 Initial Contacts in need of screening, select [Basic Search](#)

Outreach Event / Activity / Location:  -Select Outreach Event-

Contact Date: Begin Range  End Range

Patient Last:

Patient First:

Patient DOB:  Format: mm/dd/yyyy

Patient City:

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home  
▶ User Administration  
▶ CHW Training  
• Logoff

**Patient Profile: CHW Training**

**Percy Perfect**

[Complete the IPO Community Health Screening Form](#)

Client Status	Initial Contact
Status Assignment Date	06/10/2014
Referral Date	06/10/2014
EDC Date	10/09/2014
Birth Date	03/30/1991



# Access Patient Profile

In **Patient Profile** you have the option to:

- Review/Complete the **IPO Community Health Screening Form**
- Add outreach efforts, referrals, resources, or appointments regardless of whether client has been forwarded to Central Intake or to a Home Visiting program.
- Record outcomes of referrals, resources, or appointments.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home
- ▶ User Administration
- ▶ CHW Training
- Logoff

**Patient Profile: CHW Training**

**Percy Perfect**

[Complete the IPO Community Health Screening Form](#)

Client Status	Initial Contact
Status Assignment Date	06/10/2014
Referral Date	06/10/2014
EDC Date	10/09/2014
Birth Date	03/30/1991
Client Engagement Event?	Training Health Fair

**Patient Information**

Street	1 Main St
City, Zip	Camden 98765
County	Camden County
Home Phone	888-888-8888
Cell Phone	

**Other Information**

Language	English
Race	Multi-Racial

**Referring Agency Information**

Referring Agency	System Training Institute
Agency Address	2500 McClellan Ave. Pennsauken, NJ 08109
Agency Phone	(856) 665-6000

**Patient Encounters**

Date	Method	Outcome	Appt/Ref

**Program / Status History**

Program	Status	Initial Contact	Pending Enrollment	Enrollment	Pending Close	Closed	Closed Reason
CHW Training	Initial Contact	06/10/14	N/A	N/A	N/A	N/A	N/A

# Community Health Screen

18

To complete the Community Health Screen:  
From CHW Menu

- Click **Initial Contact**
- Click **Search/Modify**
- Select the client from the list of Incomplete Screenings
- OR use [Advanced Search](#)
- Click client name to select the client record
- From Patient Profile, Click "[Complete the IPO Community Health Screening Form](#)"

The image displays three screenshots of the PRA|SPECT system interface. The top screenshot shows the 'IPO Initial Contact: Basic Search' results page with a table of clients and a red circle around the 'Advanced Search' link. The middle screenshot shows the 'Patient Profile: CHW Training' for 'Percy Perfect' with a red circle around the 'Complete the IPO Community Health Screening Form' link. The bottom screenshot shows the 'Community Health Screening' form with various fields for referral information, participant details, and screening questions.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**IPO Initial Contact: Basic Search**  
You are viewing Basic Search Results for the Last 25 Initial Contacts in need of screening. To access additional search options, select [Advanced Search](#)

Contact Date	Client Name	CHW	Status
Daily Street Outreach			
06/12/2014	Special Lady	Isaac Pool	Screening Incomplete
Public Setting			
02/04/2014	James Kelly	Isaac Pool	Screening Incomplete
SNJPC Luau			
04/01/2014			
Thursday			
04/03/2014			
Training Hours			
06/10/2014			
Wednesday			
04/16/2014			

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**Patient Profile: CHW Training**

**Percy Perfect**

[Complete the IPO Community Health Screening Form](#)

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**Community Health Screening**

Referral Date\* 06/10/2014 Patient ID

Referral Type\*  Agency  Outreach  Self

Is this a Board of Social Services Referral?  Yes  No

Is this a DCSP Referral\* (Formerly DFS)?  Yes  No If Yes, was case closed?  Yes  No  N/A

Provider/Agency/Facility making the Referral\* System Training Institute / CHW Training

Last Name\* Turner First Name\* Tina Title\*

Email Address

Phone\* 999-999-9999 Fax

Participant Is.....  Preconceptional Woman  Pregnant Woman  Interconceptional Woman  Male

Has no children and has never been pregnant  Yes  No

First Time Parent  Yes  No

In Prenatal Care  Yes  No

Due Date 10/09/2014

Ages of Children in need of service: 1. None 2. 3.

Are you a parent?  Yes  No

First Time Parent?  Yes  No

Children live with you?  Yes  No

Save

©2014 PRA | SPECT

**IMPORTANT:**

- Be sure to check your work for spelling errors and accuracy before and during entry online.
- No corrections can be made once a record has been submitted.

# Community Health Screen

19

## Section 1 – Referral Information

- Information from the Initial Referral Form will auto-fill into the Community Health Screen (CHS) form.
- Click **Save** to save your entry and move to the next section.

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home | Exit  
• Referral Information  
• Participant Information  
• General Medical Information  
• Psychosocial Risk Factors  
• Pregnant Client  
• Referrals/Education  
• Participant Consent  
• Review | Save | Submit

### Community Health Screening

Referral Date*	06/10/2014	Patient ID	
<b>About the Referral Agency and Person making the referral</b>			
Referral Type*	<input type="radio"/> Agency <input checked="" type="radio"/> Outreach <input type="radio"/> Self		
Is this a Board of Social Services Referral*	<input type="radio"/> Yes <input type="radio"/> No		
Is this a DCP&P Referral* (formerly DYFS)	<input type="radio"/> Yes <input type="radio"/> No	If Yes, was case closed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Provider/Agency/Facility making the Referral*	System Training Institute / CHW Training		
Last Name*	Turner	First Name*	Tina
Title*			
Email Address			
Phone*	999-999-9999	Fax	
<b>Participant is....</b>			
<input type="radio"/> Preconceptional Woman	Has no children and has never been pregnant		
<input checked="" type="radio"/> Pregnant Woman	First Time Parent	<input checked="" type="radio"/> Yes <input type="radio"/> No	
	In Prenatal Care	<input checked="" type="radio"/> Yes <input type="radio"/> No	
	Due Date	10/09/2014	
<input type="radio"/> Interconceptional Woman	Ages of Child/ren in need of service	<input type="checkbox"/> None	
		1. <input type="text"/>	
		2. <input type="text"/>	
		3. <input type="text"/>	
<input type="radio"/> Male	Are you a parent?	<input type="radio"/> Yes <input type="radio"/> No	
	First Time Parent?	<input type="radio"/> Yes <input type="radio"/> No	
	Child/ren live with you?	<input type="radio"/> Yes <input type="radio"/> No	

**Save**

© 2014 PRA | SPECT

# Community Health Screen

## Section 2 – Participant Information

- Complete as much information as possible.
- All required information marked with an \* must be completed.
- Click **Save** to save your entry and move to the next section.

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home | Exit
- Referral Information
- **Participant Information**
- General Medical Information
- Psychosocial Risk Factors
- Pregnant Client
- Referrals/Education
- Participant Consent
- Review | Save | Submit

### CHW Participant Intake

**Participant Information**

Last Name*	Lady	First Name*	Special
Street Address *	12 Something Street		Apt/Suite/FI
City *	Camden	Zip *	98765
		County *	Camden
DOB*	07/05/1986 x	Participant ID	

**Participant Contact Information**

Primary Phone *	999-966-6666	Preferred Contact Method?
		<input checked="" type="radio"/> Primary Phone <input type="radio"/> Alternate Phone <input type="radio"/> Email <input type="radio"/> Text
Alt Phone		At which number can we text?
		<input checked="" type="radio"/> Primary <input type="radio"/> Alternate <input type="radio"/> None
Email		

**Household Information**

Children in Household?	
0-30d	6-8y
1-12m	9-14y
1-2y	15-17y
3-5y	18-19y

**Additional Participant Information**

Primary Language	English	Ethnicity	Hispanic <input type="radio"/> Yes <input checked="" type="radio"/> No	Insurance	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> NJ Family Care <input type="checkbox"/> Commercial <input checked="" type="checkbox"/> None
Other		Race	Multi-Racial	MCO	-Select MCO-

Current Height	0 Ft 0 In	<b>Pregnancy History</b> <input type="checkbox"/> N/A
Current Weight	lbs	0 How many times have you been pregnant?
Most Recent Live Birth		0 How many times did baby arrive ontime? gte 38wks
Infant Birth Weight	0 lbs 0 oz	0 How many times did baby arrive too soon? lte 37wks
		0 How many pregnancies resulted in termination?
		0 How many pregnancies resulted in miscarriage?
		0 How many pregnancies were still births?
		0 How many living children do you have?

**Did you or a family member have any of these issues when you tried to get healthcare in the past?**

<input checked="" type="checkbox"/> No insurance for myself	<input type="checkbox"/> No transportation
<input type="checkbox"/> No insurance for my children	<input type="checkbox"/> No childcare
<input type="checkbox"/> No money for co-pays	<input type="checkbox"/> Could not miss work
<input type="checkbox"/> Could not find a doctor	<input type="checkbox"/> No time
<input type="checkbox"/> Could not get an appointment	<input type="checkbox"/> Staff was rude
<input type="checkbox"/> Did not think going to the doctor was important	<input type="checkbox"/> Other: _____

**Participant Notes (External)**  
 Notes

**Participant Notes (Internal)**  
 Notes

Save

**Participant Notes:**  
**External** - can be viewed by Central Intake and Home Visiting Programs.  
**Internal** - can be viewed by your agency only.

© 2014 PRA | SPECT

# Community Health Screen

21

## Section 3 – General Medical Information

- Fill in as much information as possible.
- If a mistake is made, click Reset Form to clear the page.
- Click **Save** to save your entry and move to the next section.

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home | Exit
- Referral Information
- Participant Information
- **General Medical Information**
- Psychosocial Risk Factors
- Referrals/Education
- Participant Consent
- Review | Save | Submit

### General Medical Conditions

	Y	N	On Meds	Patient History	Unk		Y	N	On Meds	Patient History	Unk
Allergies	<input checked="" type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Hypertension	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lupus	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Blood Disorder	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological Condition	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/ Mental Illness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive/ Bleeding Gums	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>						

Reset Form Save

© 2014 PRA | SPECT

# Community Health Screen

## Section 4 – Psychosocial Risk Factors

- Fill in as much information as possible.
- Click **Save** to save your entry and move to the next section.

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home | Exit
- Referral Information
- Participant Information
- General Medical Information
- **Psychosocial Risk Factors**
- Referrals/Education
- Participant Consent
- Review | Save | Submit

### Medical/Psychosocial Risk Factors

Psychosocial Risk Factors					
	Y	N		Y	N
Disabled	<input type="radio"/>	<input checked="" type="radio"/>	Tobacco Use	<input checked="" type="radio"/>	<input type="radio"/>
Unemployed/Inadequate Income	<input type="radio"/>	<input checked="" type="radio"/>	Alcohol	<input type="radio"/>	<input checked="" type="radio"/>
Husband/Partner is Unemployed	<input type="radio"/>	<input checked="" type="radio"/>	Drug Use	<input checked="" type="radio"/>	<input type="radio"/>
Homeless	<input type="radio"/>	<input checked="" type="radio"/>	Nutritional Concerns	<input type="radio"/>	<input checked="" type="radio"/>
Unstable Housing	<input checked="" type="radio"/>	<input type="radio"/>	Perinatal Depression	<input checked="" type="radio"/>	<input type="radio"/>
Education < 12 years	<input checked="" type="radio"/>	<input type="radio"/>	Eating Disorder	<input type="radio"/>	<input checked="" type="radio"/>
Currently in Foster Care	<input type="radio"/>	<input checked="" type="radio"/>	Domestic Violence	<input type="radio"/>	<input checked="" type="radio"/>
Transportation	<input checked="" type="radio"/>	<input type="radio"/>	Low Income	<input checked="" type="radio"/>	<input type="radio"/>
Inadequate Social Support	<input checked="" type="radio"/>	<input type="radio"/>	Unplanned Pregnancy	<input type="radio"/>	<input checked="" type="radio"/>

#### Primary Care

Where do you go when you are sick?

Private Doctor/Clinic  
 Emergency Room  
 No Where  
 Other

Where do you go for check-ups?

Private Doctor/Clinic  
 Emergency Room  
 No Where  
 Other

#### Environmental Exposures

##### Lead

Home built before 1978

##### Tobacco

2nd or 3rd Hand Smoke

##### Reproductive Life Plan

Are you trying to get pregnant?

If no, are you using contraceptives?

What type of contraceptives?

Barrier  Implant  Oral  Other

**Save**

© 2014 PRA | SPECT

# Community Health Screen

## Section 5 – Pregnant Client

- All required information must be completed.
- The pregnant client section will not appear for Preconceptional, Interconceptional, or Male Clients.
- Click **Save** to save your entry and move to the next section.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home | Exit
- Referral Information
- Participant Information
- General Medical Information
- Psychosocial Risk Factors
- **Pregnant Client**
- Referrals/Education
- Participant Consent
- Review | Save | Submit

### Pregnant Client

Was the Family affected by Hurricane Sandy?  Yes  No

Is family Sandy (SSDG) funded?  Yes  No  Unknown

**Entry into Prenatal Care**

**Smoking**

Date of first visit\*

LMP\*

EDD\*

Pre Pregnancy Weight (lbs)

Bleeding during current pregnancy?  1st  2nd  3rd  No

	Current Preg			Prior Preg			Unk
	Y	N		Y	N		
Abnormal Pap	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Cervical Incompetence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Ectopic Pregnancy	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Gestational Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Group B Strep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
LBW (<2500gm)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Multiple Gestation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Obesity	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Opioid Replacement Tx	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
PIH/Preeclampsia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Previous C Section	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Rh Negative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
STD	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Uterine Abnormalities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

**4Ps Plus**

Did either of your parents have a problem with drugs or alcohol? \*  Yes  No

Does your partner have any problem with drugs or alcohol? \*  Yes  No

Have you ever felt manipulated by your partner? \*  Yes  No

Have you ever felt out of control or helpless? \*  Yes  No

Over the past 2 weeks have you felt down, depressed or hopeless? \*  Yes  No

Over the past 2 weeks have you felt little interest or pleasure in doing things? \*  Yes  No

Have you ever drunk beer/wine/liquor? \*  Yes  No

In the month before you knew you were pregnant, how many cigarettes did you smoke? \*  Any  None

In the month before you knew you were pregnant, how much wine/beer/liquor did you drink? \*  Any  None

In the month before you knew you were pregnant, how much marijuana did you use? \*  Any  None

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

In the month before you knew you were pregnant:	Refer for Assessment		Prevention Education		No Referral Needed	
	Every Day	3-6 Days/wk	1-2 days/wk	<1 day/wk	No drugs/drinks	
About how many days a week did you usually drink, beer, wine, or liquor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
use any drug such as marijuana, cocaine, or heroin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
And now, about how many days a week do you usually drink, beer, wine, or liquor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
use any drug such as marijuana, cocaine, or heroin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

**IMPORTANT:**  
All 4Ps Plus questions must be filled in. If  Any is selected for any of the last 3 questions, the Follow-up section **MUST** be completed. Your form will not be processed without this information.

# Community Health Screen

## Section 6 – Referrals/Education

- **Completed/Enrolled** – The client has completed or is actively enrolled in this program or service (i.e.: has been receiving Food Stamps for the past year.)
- **Referred** – CHW has referred client to this service or program during this referral process.
  - To move client to Central Intake, “**Referred**” must be selected for CI, CHV or both.
- **Refused** – Client has refused the service or program offered by the CHW during this referral process.
- Click **Save** to save your entry and move to the next section.

### PRA|SPECT

Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

© 2014 PRA | SPECT

- Home | Exit
- Referral Information
- Participant Information
- General Medical Information
- Psychosocial Risk Factors
- Pregnant Client
- Referrals/Education**
- Participant Consent
- Review | Save | Submit

#### Referrals/Education

	Completed/Enrolled	Referred	Refused		Completed/Enrolled	Referred	Refused
	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	Primary Care	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
Tobacco Cessation	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="radio"/>	SSI	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse Prevention Education	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	DCP&P	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse Assessment	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<b>Central Intake*</b>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="radio"/>
Mental Health Assessment	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	Preterm Labor Prevention	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
Domestic Violence Assessment	<input type="checkbox"/>	<input type="radio"/>	<input checked="" type="radio"/>	Diabetes Care Program	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
TANF/GA	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="radio"/>	Nutritional Consult	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
Emergency Assistance	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	Breast Feeding Consult	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
Food Stamps	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="radio"/>	<b>Community Home Visit*</b>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="radio"/>
WIC	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="radio"/>	Childbirth Education	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>
Dental	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<b>Community Health Worker*</b>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="radio"/>

\* Required Field

Reset Form
Save



# Community Health Screen

25

## Section 7 – Participant Consent

- Be sure to fully read and explain the consent to the client.
- Consent must be given orally or by signature on the paper form.
- Consent is the choice of the client only, not the CHW.
- Click **Save** to save your entry.
- **Click Review | Save | Submit to move to the next screen.**

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

- Home | Exit
- Referral Information
- Participant Information
- General Medical Information
- Psychosocial Risk Factors
- Pregnant Client
- Referrals/Education
- Participant Consent
- Review | Save | Submit

### Participant Consent

<b>Initial Contact Consent</b>	I agree to provide the information above and to have it forwarded as a referral to available service agencies in my community. I agree to be contacted, and for Improving Pregnancy Outcomes staff to follow-up with me or the agency to which I was referred to support my care.	Yes
<b>Participant Consent</b>	I give permission to share the information on this form with the Community Health Worker to make and follow-up on the appropriate referrals. I agree to be contacted, and for IPO staff to follow-up with me or the agency to which I was referred to support my care. Confirmation of this consent is on file at the referring agency.	<input type="radio"/> No Consent <input checked="" type="radio"/> Yes, Oral Consent <input type="radio"/> Yes, Written Consent
<b>Additional Consent</b>	I agree to provide the information regarding my health and social service needs and to be referred to a Central Intake. If a referral is made, I agree to be contacted by program staff.	<input type="radio"/> No Consent <input checked="" type="radio"/> Yes, Oral Consent <input type="radio"/> Yes, Written Consent

Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

**Save**

© 2014 PRA | SPECT

# Community Health Screen

26

## Section 8 – Review | Save | Submit

- **Save** – Will save the form, from the last point of entry. The form can be retrieved for later completion. **\*Form will not be submitted\***
- **Submit** – Form will be submitted to Central Intake for further processing. Changes may not be made once the form has been submitted.
  - **Be sure to review and check your work for spelling errors and accuracy before submitting.**
  - **No corrections can be made to the record once the form has been submitted.**
- **Remove** – Form will be completely deleted from the system and cannot be retrieved and will not be submitted to Central Intake.
- Click **Enter Selection** to save your entry and submit the form.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home | Exit  
• Referral Information  
• Participant Information  
• General Medical Information  
• Psychosocial Risk Factors  
• Pregnant Client  
• Referrals/Education  
• Participant Consent  
• **Review | Save | Submit**

Community Health Screening Review / Submit

CHS Form Options		
<input type="radio"/> Save	<b>Save the CHS Form</b>	The form will be retrievable to complete. All required fields must be complete to submit the form.
<input checked="" type="radio"/> <b>Submit</b>	<b>Submit the CHS Form</b>	The form will be submitted to Central Intake for processing. Submitted forms cannot be removed from the system.
<input type="radio"/> Remove	<b>Remove the CHS Form</b>	The form will be removed from the system and all information will be deleted.

**Enter Selection**

© 2014 PRA | SPECT

# Newly Assigned Patients List

27

Once a client has gone through the referral process, the client will be assigned to your CHW program if:

- The client has refused CI or CHV
  - The client is ineligible for a Home Visiting Program
  - No Home Visiting Program is available.
- 
- CHW supervisor assigns the client to a CHW staff member.
  - CHW will check the **Newly Assigned Patient List** daily for new clients.
  - Click the client's name to Access the Patient Profile.
  - Once the client agrees to participate in CHW program, your supervisor will need to change status to **"Enrolled"**.
    - Enrolled clients assigned to you will appear in your **"Enrolled Patients List"**.

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home  
▶ User Administration  
▼ CHW Training  
▶ Initial Contact  
▼ Patients  
• **Newly Assigned Patients List**  
• Enrolled Patients List  
• Closed Patients List  
▶ Forms  
▶ IPO Administration  
• Logoff

**Newly Assigned Patient Search Results**

**CHW Training**

Referral Date	Patient Name	Patient DOB	Staff	Program Status	Assigned Date
06/10/14	Perfect, Percy	03/30/91	Pool	Pending Enrollment	06/13/14
06/11/14	Monae, Funnie	08/20/96	Pool	Pending Enrollment	06/11/14

© 2014 PRA | SPECT

# Newly Assigned Patients List

28

**IMPORTANT:** SPECT must be checked for new referrals at least **daily**. For your convenience, a daily email alert is automatically generated (at midnight) to alert you when new clients are assigned to your program during the preceding 24 hours.

From: sysAdmin@praspect.org

To: lpool@chw.training.com

Cc:

Subject: FW: CI Client Assignment Summary

From: [sysAdmin@praspect.org](mailto:sysAdmin@praspect.org) <[sysAdmin@praspect.org](mailto:sysAdmin@praspect.org)>

Sent: Wednesday, June 18, 2014 11:47 PM

To: [lpool@chw.training.org](mailto:lpool@chw.training.org)

Cc: [SPECT@snjpc.org](mailto:SPECT@snjpc.org)

Subject: CI Client Assignment Summary

The following is a summary of clients assigned to you on Wed, Jun 18, 2014:

**CHW Training**

CHW Training 3

This message was autogenerated and has no monitored email box. Please do not reply to this message.

# Enrolled Patients List

29

## To access your caseload

From CHW Menu

- Click **Patients**
- Click **Enrolled Patients List**
  - Enrolled Patient List will show the CHW's clients only.
  - Click on any of the [Blue Headings](#) to sort lists.
- Click the client's name to access the Patient Profile.

**PRA | SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home  
▶ User Administration  
▼ CHW Training  
▶ Initial Contact  
▼ Patients  
• Newly Assigned Patients List  
• **Enrolled Patients List**  
• Closest Patients List  
▶ Forms  
▶ IPO Administration  
• Logoff

**Enrolled Patient Search Results**

**CHW Training**

Referral Date	Patient Name	Patient DOB	Program Status	Program Status Date	Staff	Assignment Date
05/15/13	<a href="#">Poodle, Polly</a>	05/12/85	Enrolled	06/11/14	Pool	04/11/14
02/21/14	<a href="#">Jessel, Boston</a>	08/15/67	Enrolled	06/11/14	Pool	06/10/14
03/14/14	<a href="#">Sunshine, Sammy</a>	07/09/90	Enrolled	05/09/14	Pool	03/14/14
03/18/14	<a href="#">Koolquy, Kevin</a>	01/01/98	Enrolled	04/09/14	Pool	04/09/14
04/08/14	<a href="#">Lady, Preg</a>	07/15/82	Enrolled	04/29/14	Pool	04/16/14
04/09/14	<a href="#">June, May</a>	02/08/89	Enrolled	04/11/14	Pool	04/10/14
06/10/14	<a href="#">Perfect, Percy</a>	03/30/91	Enrolled	06/16/14	Pool	06/13/14
06/11/14	<a href="#">Blinds, Closed</a>	08/07/70	Enrolled	06/11/14	Pool	06/11/14
06/12/14	<a href="#">Lady, Special</a>	07/05/86	Enrolled	06/16/14	Pool	06/12/14

© 2014 PRA | SPECT

# Closed Patients List

Once a client has completed services or for any of the “Close” reasons, your supervisor will close the patient record and it will be moved to the “Closed Patient List”.

- CHW Supervisor must change the status from “Pending Enrolled” or “Enrolled” to “Closed” when the client completes services, refuses services, etc.
- Once a client is Closed – client is moved from Pending Enrolled (*Newly Assigned Patients List*) or Enrolled Patients List to Closed Patients List.
- Closed clients can be reopened if additional services are needed within that referral timeframe.
- New contacts can be recorded for closed clients in Engagement/Encounters section.
- New Referrals, Resources, or Appointments can be recorded in Engagement/Encounters section.
- Status and outcome dates for existing Referrals, Resources, or Appointments can be recorded and updated.

The screenshot displays the PRA|SPECT software interface. On the left is a navigation menu with options: Home, User Administration, CHW Training, Initial Contact, Patients (expanded), Newly Assigned Patients List, Enrolled Patients List, Closed Patients List (circled in red), Forms, IPO Administration, and Logoff. The main content area is titled 'Closed Patient Search Results' (circled in red) and 'CHW Training'. It contains a table with the following data:

Referral Date	Patient Name	Patient DOB	Assigned Staff	Program Status	Assignment Date
11/08/13	<a href="#">Jones, Maria</a>	06/21/82	Pool	Closed    Case Completed	04/17/14
02/21/14	<a href="#">Jessel, Boston</a>	08/15/67	Pool	Closed    Client Refused	04/08/14
02/21/14	<a href="#">Skies, Grey</a>	04/26/98	Pool	Closed    Referrals Completed	02/21/14
03/18/14	<a href="#">Seas, Stormy</a>	07/19/95	Pool	Closed    Referrals Completed	03/18/14
03/18/14	<a href="#">Blossom, Spring</a>	07/19/94	Pool	Closed    Case Completed	05/09/14
04/07/14	<a href="#">Bird, Red</a>	08/05/79	Pool	Closed    Case Completed	05/21/14
04/09/14	<a href="#">Pink, Donna</a>	10/25/87	Pool	Closed    No longer Pregnant	04/09/14
04/16/14	<a href="#">client, fake</a>	02/25/90	Pool	Closed    Referrals Completed	04/17/14

© 2014 PRA | SPECT

# Adding Engagements/Encounters Resources, Referrals and Appointments

31

## Access the Patient Profile Screen

- Click the green “**plus sign**” to add a new contact, resource or referral provided, or appointment made.
- To view an existing contact, click [View](#)
- To open an existing contact, click the [Date](#)

**Patient Profile: NFP Training**

**Sally Smith**

Client Status	Enrolled
Status Assignment Date	05/22/2014
Is Client MIHOPE Participant	No
MIHOPE Client ID	Missing Required Information
Referral Date	01/23/2014
EDC Date	07/01/2014
Birth Date	06/09/1995

**Patient Information**

Street	56 Elm Street
City, Zip	Camden 98765
County	Camden County
Home Phone	856-598-5565
Cell Phone	

**Other Information**

Language	Spanish
Race	Hispanic

**Referring Agency Information**

Referring Agency	System Training
Agency Address	2500 McClellan Pennsauken,
Agency Phone	(856) 665-6000

**Patient Encounters**

Date	Method	Outcome	Appt/Ref
<a href="#">05/22/14</a>	Home Phone	Contacted	<a href="#">View</a>
Appointment Date	05/23/2014	Agency Type	Home Visiting
Outcome	Appointment Kept	Outcome Date	05/23/2014
Notes	client enrolled.		
<a href="#">05/06/14</a>		Other	N/A

**Program / Status History**

Program	Status	Pending Enrollment	Enrollment	Pending Close	Closed	Closed Reason
NFP Training	Enrolled	05/22/14	05/22/14	N/A	N/A	N/A

# Add Encounter/Engagement

32

- Encounter/Engagements (Client Contacts) must be entered and saved prior to adding any referrals, appointments, or resources.
- A contact date must be entered in order to save and later retrieve the Encounter/Engagement record.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

Central Intake Encounter/Engagement

**Sammy Sunshine**

Program	CHW Training
Contact Date	05/22/2014
Contact Method	Cell Voice
Contact Outcome	Contacted
Contact Notes	

Back to List **Save Contact**

© 2014 PRA | SPECT

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

Central Intake Encounter/Engagement

The contact/encounter record was successfully added. Select the link below to add a referral, appointment, or resource

**Sally Smith**

Program	NFP Training
Contact Date	05/22/2014
Contact Method	Cell Voice
Contact Outcome	Contacted
Contact Notes	made referral to prenatal care

[Add New Referral, Appointment, or Resource](#)

Back to List **Save Contact**

© 2014 PRA | SPECT



# Resources, Appointments and Referrals

33

**Referrals, Appointments, and Resources can be added and updated at any level of client contact or enrollment status:**

- Initial Contacts
- New Clients
- Pending Enrolled Clients
- Enrolled Clients
- Pending Closed Clients
- Closed Clients

**Resource** - General service and agency information that has been given or sent to the client.

**Referral** - Information given to client to contact or make appointments with a provider, social service agency or program.

**Appointment** - Specific dates and times that have been set up for a client to meet with a provider or agency.

# Add New Referral, Appointment, or Resource

34

## Add New Referral, Appointment, or Resource

- Search appropriate client list (**Initial contacts, New Referrals, Enrolled, etc.**)
- Search and Select **Patient Profile**
- Select the clients name from the appropriate list to open the **Patient Profile**

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

• Home  
▶ User Administration  
▶ CHW Training  
▶ HF Training  
▼ NFP Training  
▶ Referrals  
▼ Patients  
• Newly Assigned Patients List  
• **Enrolled Patients List**  
• NFP Patients List  
• Closed Patients List  
▶ Forms  
▶ PAT Training  
• Logoff

**Enrolled Patient Search Results**  
NFP Training

Referral Date	Patient Name	Patient DOB	Program Status	Program Status Date	Staff	Assignment Date
07/18/13	<a href="#">Wunpage, Winnie</a>	08/05/95	Enrolled	01/23/14	Smith	05/06/14
09/05/13	<a href="#">Jolly, Jessie</a>	09/26/90	Enrolled	12/12/13	Smith	02/20/14
10/14/13	<a href="#">Nabbit, Dag</a>	07/08/98	Enrolled	04/24/14	Staff	12/18/13
11/04/13	<a href="#">Electra, Carman</a>	07/01/97	Enrolled	05/06/14	Smith	11/07/13
01/13/14	<a href="#">Kane, Candy</a>	04/26/85	Enrolled	04/24/14	Staff	01/23/14
01/22/14	<a href="#">Needy, Nancy</a>	04/26/98	Enrolled	04/24/14	Staff	04/24/14
01/23/14	<a href="#">Smith, Sally</a>	06/05/95	Enrolled	05/22/14	Staff	05/22/14
01/24/14	<a href="#">Hudson, Patty</a>	04/26/90	Enrolled	02/28/14	Staff	02/28/14

©2014 PRA | SPECT

# Service Type and Service Provider Information

35

- Add all Referrals, Appointments, or Resources individually – See following pages for detailed instructions
  - You must **“Save”** after each entry before adding the next record
  - There is no limit on the number of Referrals, Appointments, or Resources that can be made/entered for a client.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**Service Type and Service Provider Information**

Date:

Type:  Resource - General service information has been given/sent.  
 Referral - Information to contact/make appointment with a Provider.  
 Appointment - A date/time has been set up with a Provider.

Service Programs / Providers

Type:

Program:

Provider:

**Status and Outcome Information**

Status:

Outcome:  Outcome Date:

**Notes / Comments**

General Notes - Information seen by any user with access to patient record

Internal Notes - Information seen by the user and individuals in the same agency

© 2014 PRA | SPECT

# Service Programs/Providers - Types

36

- **Service Programs/Providers**
  - Community Based Agency Support
    - Basic Needs/General
    - Behavioral Health
    - Child Care
    - Community Centers
    - Domestic Violence
    - Early Head Start/Head Start
    - Early Intervention System
    - Education
    - Emergency Housing
    - Family Success Center
    - Fatherhood Services
    - Food Centers
    - Housing
    - Insurance Services
    - Job Training Program
    - Parenting Groups
    - School Based services
    - Smoking Cessation
    - Substance Abuse
    - TANF
    - Transportation
    - WIC/Nutrition

# Service Programs/Providers - Types

- **Service Programs/Providers – Continued**
  - Community Home Visiting
    - Healthy Families
    - Infant and Family Development
    - Local Health Department IPO
    - Nurse Family Partnership
    - Other social service
    - Out-of-Service Area
    - Parents as Teachers
  
  - Outreach and Case Management
    - ACA Navigators
    - Community Health Worker
    - CP&P Child Protective Services
    - DCP&P
    - Health Related Case Management
    - IPO Outreach and Case Management
    - Special Child Health Care
  
  - Primary Medical Care
    - Dental Services
    - Family Health
    - Hospitals
    - Pediatric
    - Pregnancy Testing
    - Prenatal
    - Primary Medical Care - Children
    - Primary Medical Care - Mother
    - Primary Medical Care - Other
    - Women's Health

# Add Resource

## Adding a Resource provided to client:

- Selection options will change as you select the different types of programs

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**\* Select the appropriate choices.**  
**\* Each Service Program/Provider will change with each Type selected**

**Service Type and Service Provider Information**  
Date: 05/22/2014  
Type:  Resource - General service information has been given/sent.  
 Referral - Information to contact/make appointment with a Provider.  
 Appointment - A date/time has been set up with a Provider.

**Service Programs / Providers**  
Type: - Select -  
Program: Community Based Agency Support  
Provider: Outreach and Case Management

**Status and Outcome Information**  
Status: -Select Status-  
Outcome: -Select Outcome- Outcome Date:

Notes / Comments

- Select Type = Resource
- Select Service Program/Provider
- Select Provider

**Service Type and Service Provider Information**  
Date: 05/22/2014  
Type:  Resource - General service information has been given/sent.  
 Referral - Information to contact/make appointment with a Provider.  
 Appointment - A date/time has been set up with a Provider.

**Service Programs / Providers**  
Type: Community Based Agency Support  
Program: - Select Program -  
Provider: - Select Provider -

**Status and Outcome Information**  
Status: -Select Status-  
Outcome: -Select Outcome- Outcome Date:

**Notes / Comments**  
General Notes - Information seen  
Internal Notes - Information seen

# Status and Outcome Information

## Recording and Tracking Status and Outcome Information:

- Select Status
  - Open
  - Pending
  - Closed
  - Other
- Select Outcome
  - Appointment Specific
    - Appointment Kept
    - Appointment Cancelled
    - Appointment Rescheduled
  - Referral Specific – by Participant
    - Attempted Contact
    - Contacted
    - Made Appointment
    - Met with
  - Referral Specific – by Provider
    - Attempted Contact
    - Contacted
    - Made Appointment
    - Met with
  - General
    - Did not meet need
    - Unknown Outcome
    - Outcome N/A
- Enter Outcome Date
- Add Notes/Comments
  - General Notes – Information seen by any user with access to the patient/client record.
  - Internal Notes – Information seen by the user and individuals within the same agency.

# Status and Outcome Information

40

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**Service Type and Service Provider Information**

Date: 05/22/2014

Type:  Resource - General service information has been given/sent.  
 Referral - Information to contact/make appointment with a Provider.  
 Appointment - A date/time has been set up with a Provider.

Service Programs / Providers

Type: Community Based Agency Support

Program: Basic Needs/General

Provider: - Select Provider -

**Status and Outcome Information**

Status: Open

Outcome: -Select Outcome- Outcome Date: [Calendar]

**Notes / Comments**

General Notes - Inform: [Text Area]

Internal Notes - Inform: [Text Area]

**Outcome Dropdown Menu:**

- Appointment Specific
  - Appointment Made
  - Appointment Cancelled
  - Appointment Rescheduled
- Referral Specific - by Participant
  - Attempted Contact
  - Contacted
  - Made Appointment
  - Met with
- Referral Specific - by Provider
  - Attempted Contact
  - Contacted
  - Made Appointment
  - Met with
- General
  - Did not meet need
  - Unknown Outcome
  - Outcome N/A

Return/Cancel Save

- Once saved, you will be brought back to **Encounter/Engagement**
- Additional records may be added without exiting the patient profile.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**Central Intake Encounter/Engagement**

**Sammy Sunshine**

Program: CHW Training

Contact Date: 05/22/2014

Contact Method: Cell Voice

Contact Outcome: Contacted

Contact Notes: [Text Area]

[Add New Referral, Appointment, or Resource](#)

Resource			
Date	05/22/2014		
Service Programs / Providers	Community Based Agency Support --> Basic Needs/General		
<b>Status: Open</b>			
Outcome	N/A	Outcome Date	05/22/2014
General Notes	[Text Area]		
Internal Notes	[Text Area]		

Back to List Save Contact



# Add Referral

41

## Adding a Referral provided to client

- Selection options will change as you select the different types of programs

The screenshot shows the PRA|SPECT web application interface. The header includes the logo 'PRA|SPECT' and the text 'Perinatal Risk Assessment Single Point of Entry and Client Tracking System'. The main form is titled 'Service Type and Service Provider Information' and contains the following fields:

- Date:** 05/23/2014
- Type:** Radio buttons for 'Resource - General service information has been given/sent.', 'Referral - Information to contact/make appointment with a Provider.' (selected), and 'Appointment - A date/time has been set up with a Provider.'
- Service Programs / Providers:**
  - Type:** Outreach and Case Management
  - Program:** DCP&P
  - Provider:** - Select Provider -
- Status and Outcome Information:**
  - Status:** -Select Status-
  - Outcome:** -Select Outcome- and **Outcome Date:** [calendar icon]
- Notes / Comments:**
  - General Notes - Information seen by any user with access to patient record:** [text area]
  - Internal Notes - Information seen by the user and individuals in the same agency:** [text area]

At the bottom right of the form are buttons for 'Return/Cancel' and 'Save'.

- Select Type - Referral
- Select Service Programs/ Providers
  - Select Type
  - Select Program
  - Select Provider (if specified)
- Select Status
- Select Outcome
  - Enter Outcome Date
- Add Notes/Comments
  - General Notes
  - Internal Notes
- Remember to Click **“Save”** after entering each service.

# Saved Referral Screen

42

**PRA | SPECT**  
 Perinatal Risk Assessment  
 Single Point of Entry and Client Tracking System

### Central Intake Encounter/Engagement

**Sally Smith**

Program	NFP Training
Contact Date	05/22/2014
Contact Method	Cell Voice
Contact Outcome	Contacted
Contact Notes	
Entry Person	Henny Supervisor

Add New Referral, Appointment, or Resource

<b>Referral</b>			
Date	05/23/2014		
Service Programs / Providers	Outreach and Case Management --> DCP&P		
<b>Status: Open</b>			
Outcome	N/A	Outcome Date	N/A
<b>Notes</b>			
General Notes			
Internal Notes			
Entry Person	Henny Supervisor		

<b>Resource</b>			
Date	05/22/2014		
Service Programs / Providers	Community Based Agency Support --> Basic Needs/General		
<b>Status: Open</b>			
Outcome	N/A	Outcome Date	N/A
<b>Notes</b>			
General Notes	Client given resource to receive diapers		
Internal Notes			
Entry Person	Henny Supervisor		

Back to List
Save Contact

© 2014 PRA | SPECT

# Add Appointment

43

## Adding an Appointment made for or with the client

- Selection options will change as you select the different types of programs

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

**Service Type and Service Provider Information**

Date: 05/22/2014

Type:  Resource - General service information has been given/sent.  
 Referral - Information to contact/make appointment with a Provider.  
 Appointment - A date/time has been set up with a Provider.

Service Programs / Providers

Type: Primary Medical Care

Program: -Select Program-

Provider: -Select Program-

**Status and Outcome Information**

Status: Closed

Outcome: Appointment

Outcome Date: 05/23/2014

**Notes / Comments**

General Notes - Information seen by the user and individuals in the same agency

Internal Notes - Information seen by the user and individuals in the same agency

Return/Cancel Save

© 2014 PRA | SPECT

- Select Type - Appointment
- Select Service Programs/Providers
  - Select Type
  - Select Program
  - Select Provider (if specified)
- Select Status
- Select Outcome
  - Enter Outcome Date
- Add Notes/Comments
  - General Notes
  - Internal Notes
- Remember to click **“Save”** after each entering each service.

# Saved Appointment Screen

44

## PRA | SPECT

Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

### Central Intake Encounter/Engagement

#### Sammy Sunshine

Program	CHW Training
Contact Date	05/22/2014
Contact Method	Cell Voice
Contact Outcome	Contacted
Contact Notes	
Entry Person	Ingrid Pod

[Add New Referral, Appointment, or Resource](#)

<b>Resource</b>			
Date	05/22/2014		
Service Programs / Providers	Community Based Agency Support --> Basic Needs/General		
<b>Status: Open</b>			
Outcome	N/A	Outcome Date	05/22/2014
<b>Notes</b>			
General Notes			
Internal Notes			
Entry Person	Ingrid Pod		

<b>Appointment</b>			
Date	05/22/2014		
Service Programs / Providers	Primary Medical Care --> Prenatal		
<b>Status: Pending</b>			
Outcome	N/A	Outcome Date	N/A
<b>Notes</b>			
General Notes			
Internal Notes			
Entry Person	Ingrid Pod		

[Back to List](#) [Save Contact](#)

# Update Outcomes

- Staff members are responsible for recording, tracking and entering/updating outcomes for all referrals, resources, and appointments
- **Remember! The outcome date must always be added.**

**Patient Profile: CHW Training**

**Sammy Sunshine**

Client Status  
 Status Assignment Date  
 Referral Date 03/14/2014  
 EDC Date  
 Birth Date 07/09/1990  
 Client Engagement Event? Informal Meeting

**Patient Information**  
 Street 99 Bright Way  
 City, Zip Camden 98765  
 County Camden County  
 Home Phone 877-898-8899  
 Cell Phone 877-898-8899

**Other Information**  
 Language English  
 Race Hub-Racial

**Referring Agency Information**  
 System Training Institute  
 2500 McClain Ave.  
 Pennsauken, NJ 08109  
 (856) 665-0000

Date	Method	Outcome	Appt./Ref
05/22/2014	Cell Voice	Contacted	N/A
05/22/2014	Cell Voice	Contacted	View

**Program / Status History**

Program	Status	Pending Enrollment	Enrollment	Pending Close	Closed	Closed Reason
CHW Training	Enrolled	05/09/14	N/A	N/A	N/A	N/A

**Central Intake Encounter/Engagement**

**Sammy Sunshine**

Program CHW Training  
 Contact Date 05/22/2014  
 Contact Method Cell Voice  
 Contact Outcome Contacted  
 Contact Notes

**Resource**  
 Date 05/22/2014  
 Service Programs / Providers Community Based Agency Support --> Basic Needs/General

Date	Outcome Date
N/A	05/22/2014

05/22/2014 Primary Medical Care --> Prenatal  
 Appointment Kept Outcome Date 05/23/2014  
 Attended Prenatal Care Appt

Back to List Save Contact

Program Basic Needs/General  
 Provider - Select Provider -

**Status and Outcome Information**  
 Status Open  
 Outcome - Select Outcome -  
 Outcome Date 05/22/2014

**Notes / Comments**  
 General Notes - Inform Appointment Specific  
 Internal Notes - Inform Referral Specific - by Participant  
 General Referral Specific - by Provider

Return/Cancel Save

# Outcome Types

46

## Outcome Types:

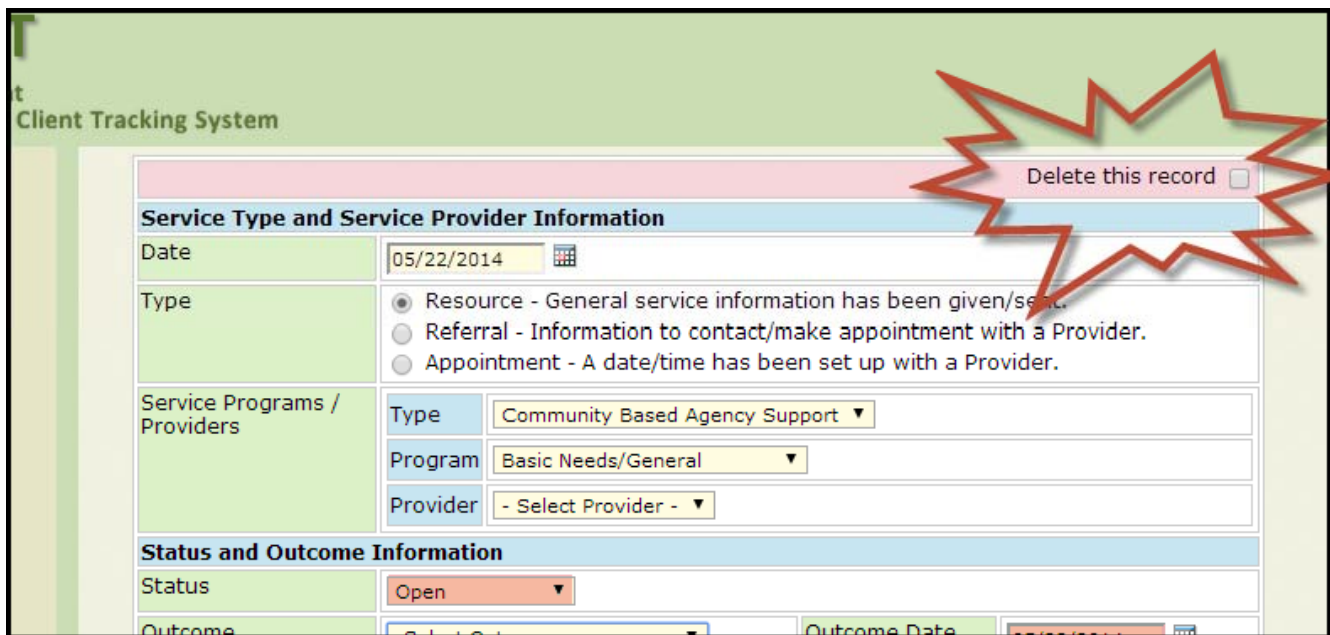
- Appointment Specific
  - Appointment Kept – Client attended scheduled appointment
  - Appointment Cancelled – Client cancelled appointment without rescheduling
  - Appointment Rescheduled – Appointment cancelled and rescheduled for another time/date
- Referral Specific – by Participant
  - Attempted Contact
  - Contacted
  - Made Appointment
- Referral Specific – by Provider
  - Attempted Contact
  - Contacted
  - Made Appointment
  - Met with
- General
  - Did not meet need
  - Unknown Outcome
  - Outcome N/A

# Deleting Incorrect Resources, Referrals, and Appointments

47

## Deleting a saved record of a Resource, Referral or Appointment

- Records should **ONLY** be deleted if the incorrect Referral, Appointment, or Resource was entered.
- If a client has declined the service, update the outcome rather than deleting the record.
- To delete a record, click “**Delete this record**” and “**Save**”
- A deleted record is removed from the system and cannot be retrieved.



The screenshot displays the 'Client Tracking System' interface. At the top left, the text 'Client Tracking System' is visible. The main content area is a form with several sections:

- Service Type and Service Provider Information**: This section includes a 'Date' field with the value '05/22/2014' and a calendar icon. Below it is a 'Type' field with three radio button options: 'Resource - General service information has been given/sent.', 'Referral - Information to contact/make appointment with a Provider.', and 'Appointment - A date/time has been set up with a Provider.' The 'Resource' option is selected.
- Service Programs / Providers**: This section contains three dropdown menus: 'Type' (set to 'Community Based Agency Support'), 'Program' (set to 'Basic Needs/General'), and 'Provider' (set to '- Select Provider -').
- Status and Outcome Information**: This section includes a 'Status' dropdown menu (set to 'Open') and an 'Outcome' field (set to '- Select Outcome -').

A red starburst graphic highlights the 'Delete this record' checkbox, which is located at the top right of the form area.

# Forms

48

### System Training Institute Referral Form

PLEASE PRINT CLEARLY

**\* REQUIRED**

**Participant Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Referral \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_  
 Zip Code \_\_\_\_\_ County \_\_\_\_\_ Participant ID \_\_\_\_\_

**Referral Agency Information**

Referral Agency Name \_\_\_\_\_  
 Name of Person making the Referral \_\_\_\_\_ Phone \_\_\_\_\_  
 Outreach Type  Agency  Self  Door to Door  Event (specify) \_\_\_\_\_  Other \_\_\_\_\_

**Primary Language** (Choose one)  English  Spanish  Other \_\_\_\_\_

**Race** (Choose one)  Black  White  Asian  Other \_\_\_\_\_

**Ethnicity**  Hispanic  Yes  No  Multi-Race  Alaska/Pacific Islander  Other \_\_\_\_\_

**Health Insurance** (Check all that apply)  
 Medicaid/FIE  Commercial/Private  
 NJ Family Care  Uninsured/Self Pay  
 Medicare

**Participant Contact Information**

Primary Phone \_\_\_\_\_  
 Alternate Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_

**Preferred Contact Method**  
 Primary Phone  Email  
 Alternate Phone  Text

**At which phone number can we text you?**  
 Primary  None  Alternate

**Household Information**

How many children live in your household? (Write the number of children for each age group.)

0-30 days	6-8 years
1-12 months	9-14 years
1-3 years	15-17 years
3-5 years	18-19 years

**Participant Sex (Choose One)**  
 Preconceptional Woman  Pregnant Woman  Interconceptional Woman  Male

Has no children and has never been pregnant?  Yes  No

**First Time Parent?**  Yes  No  
 (Does not matter if woman has children.)

**Are you a Parent?**  Yes  No  
 Does your child live w/ you?  Yes  No

**Age(s) of children needing services:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Did you or a family member have any of these issues when you tried to get healthcare in the past? (Select all that apply)**

<input type="checkbox"/> No insurance for myself	<input type="checkbox"/> No transportation
<input type="checkbox"/> No insurance for my children	<input type="checkbox"/> No childcare
<input type="checkbox"/> No money for co-pay	<input type="checkbox"/> Could not miss work
<input type="checkbox"/> Could not find a doctor	<input type="checkbox"/> No time
<input type="checkbox"/> Could not get an appointment	<input type="checkbox"/> Staff was rude
<input type="checkbox"/> Did not think going to the doctor was important	<input type="checkbox"/> Other _____

**Participant Consent**  
 I agree to provide the information above and to have it forwarded as a referral to available service agencies in the community. I agree to be contacted by the Improving Pregnancy Outcomes staff to follow up with me or the agency I referred I was referred to support my case.  
 Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Referral Agency \_\_\_\_\_ Date \_\_\_\_\_

**Program Use Only**  
 Date Pregnancy Test Given \_\_\_\_\_  
 Pregnancy Test Positive?  Yes  No

### Improving Pregnancy Outcomes Community Health Screening

PLEASE PRINT CLEARLY

**\* REQUIRED**

**Referral Information**

Referral Date \_\_\_\_\_ Patient ID \_\_\_\_\_  
 Referral Type  Agency  Outreach  Self

**Person Making Referral**  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_  
 Zip Code \_\_\_\_\_ County \_\_\_\_\_ Participant ID \_\_\_\_\_

**About the Referral Information**

Preconceptional Woman  Pregnant Woman  Interconceptional Woman  Male

Has no child and has never been pregnant?  Yes  No

**First Time Parent?**  Yes  No  
 (Does not matter if woman has children.)

**Are you a Parent?**  Yes  No  
 Does your child live with you?  Yes  No

**Age(s) of children needing services:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Participant Information**  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_  
 Zip Code \_\_\_\_\_ County \_\_\_\_\_ Participant ID \_\_\_\_\_

**Primary Language** (Choose one)  English  Spanish  Other \_\_\_\_\_

**Race** (Choose one)  Black  White  Asian  Other \_\_\_\_\_

**Ethnicity**  Hispanic  Yes  No  Multi-Race  Alaska/Pacific Islander  Other \_\_\_\_\_

**Health Insurance** (Check all that apply)  
 Medicaid/FIE  Commercial/Private  NJ Family Care  Uninsured/Self Pay  Medicare  Health First

**Current Weight (lb)** \_\_\_\_\_ **Current Height (ft)** \_\_\_\_\_

**Medical History**

How many times have you been pregnant? \_\_\_\_\_  
 How many times did your baby arrive on-time? (38 weeks or more) \_\_\_\_\_  
 How many times did your baby arrive too soon? (37 weeks or less) \_\_\_\_\_  
 How many pregnancies resulted in a termination? \_\_\_\_\_  
 How many pregnancies resulted in a miscarriage? \_\_\_\_\_  
 How many pregnancies have resulted in fetal death(s)? (stillbirth) \_\_\_\_\_  
 How many currently living children do you have? \_\_\_\_\_

**General Medical Information**

Has a doctor or other medical professional ever told you that you have any of the following conditions?

Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Allergies		Blood Disorder		Hypertension		Neurological Condition		Diabetes		Stroke		Chronic Kidney Disease		Heart Disease		Other
Asthma		Depression/Mental Illness		Diabetes		High Blood Pressure		Obesity		Other		Other		Other		Other

**Psychosocial/EMR/Enablers**

Yes	No	Yes	No
Unemployed/Underemployed		Transportation Problems	
Homeless		Food Insecurity	
Unstable Housing		Substance Use	
Education < 12 years		Alcohol	
Community & Family Care		Drug Use	
Transportation Problems		Other	
Headache/Social Support			

**When do you go when you are sick?**  
 Primary Care/Physician  Urgent Care  Emergency Room  None/Not Sure

**Where do you go for check-ups?**  
 Primary Care/Physician  Urgent Care  Emergency Room  None/Not Sure

**What type of insurance do you have?**  
 Medicaid  Commercial  NJ Family Care  Uninsured/Self Pay  Medicare  Health First

**Additional Consent**  
 I agree to provide the information on this form to the Community Health Center to make and follow-up on the appropriate referrals. I agree to be contacted, and for POC staff to follow up on the referral to the agency to which I was referred to support my case. Confirmation of this consent is on the attached agency as listed above.  
 Participant under the age of 18 understands that it is their best interest to include a trusted adult in decisions made to be health.  
 Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Referral Agency \_\_\_\_\_ Date \_\_\_\_\_

### Improving Pregnancy Outcomes Community Health Screening

PLEASE PRINT CLEARLY

**\* REQUIRED**

**Participant Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Referral \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_  
 Zip Code \_\_\_\_\_ County \_\_\_\_\_ Participant ID \_\_\_\_\_

**Referral Agency Information**

Referral Agency Name \_\_\_\_\_  
 Name of Person making the Referral \_\_\_\_\_ Phone \_\_\_\_\_  
 Outreach Type  Agency  Self  Door to Door  Event (specify) \_\_\_\_\_  Other \_\_\_\_\_

**Primary Language** (Choose one)  English  Spanish  Other \_\_\_\_\_

**Race** (Choose one)  Black  White  Asian  Other \_\_\_\_\_

**Ethnicity**  Hispanic  Yes  No  Multi-Race  Alaska/Pacific Islander  Other \_\_\_\_\_

**Health Insurance** (Check all that apply)  
 Medicaid/FIE  Commercial/Private  
 NJ Family Care  Uninsured/Self Pay  
 Medicare

**Participant Contact Information**

Primary Phone \_\_\_\_\_  
 Alternate Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_

**Preferred Contact Method**  
 Primary Phone  Email  
 Alternate Phone  Text

**At which phone number can we text you?**  
 Primary  None  Alternate

**Household Information**

How many children live in your household? (Write the number of children for each age group.)

0-30 days	6-8 years
1-12 months	9-14 years
1-3 years	15-17 years
3-5 years	18-19 years

**Participant Sex (Choose One)**  
 Preconceptional Woman  Pregnant Woman  Interconceptional Woman  Male

Has no children and has never been pregnant?  Yes  No

**First Time Parent?**  Yes  No  
 (Does not matter if woman has children.)

**Are you a Parent?**  Yes  No  
 Does your child live w/ you?  Yes  No

**Age(s) of children needing services:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Did you or a family member have any of these issues when you tried to get healthcare in the past? (Select all that apply)**

<input type="checkbox"/> No insurance for myself	<input type="checkbox"/> No transportation
<input type="checkbox"/> No insurance for my children	<input type="checkbox"/> No childcare
<input type="checkbox"/> No money for co-pay	<input type="checkbox"/> Could not miss work
<input type="checkbox"/> Could not find a doctor	<input type="checkbox"/> No time
<input type="checkbox"/> Could not get an appointment	<input type="checkbox"/> Staff was rude
<input type="checkbox"/> Did not think going to the doctor was important	<input type="checkbox"/> Other _____

**Participant Consent**  
 I agree to provide the information above and to have it forwarded as a referral to available service agencies in the community. I agree to be contacted by the Improving Pregnancy Outcomes staff to follow up with me or the agency I referred I was referred to support my case.  
 Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Referral Agency \_\_\_\_\_ Date \_\_\_\_\_

**Program Use Only**  
 Date Pregnancy Test Given \_\_\_\_\_  
 Pregnancy Test Positive?  Yes  No

### Improving Pregnancy Outcomes Community Health Screening

PLEASE PRINT CLEARLY

**\* REQUIRED**

**Participant Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Referral \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_  
 Zip Code \_\_\_\_\_ County \_\_\_\_\_ Participant ID \_\_\_\_\_

**Referral Agency Information**

Referral Agency Name \_\_\_\_\_  
 Name of Person making the Referral \_\_\_\_\_ Phone \_\_\_\_\_  
 Outreach Type  Agency  Self  Door to Door  Event (specify) \_\_\_\_\_  Other \_\_\_\_\_

**Primary Language** (Choose one)  English  Spanish  Other \_\_\_\_\_

**Race** (Choose one)  Black  White  Asian  Other \_\_\_\_\_

**Ethnicity**  Hispanic  Yes  No  Multi-Race  Alaska/Pacific Islander  Other \_\_\_\_\_

**Health Insurance** (Check all that apply)  
 Medicaid/FIE  Commercial/Private  
 NJ Family Care  Uninsured/Self Pay  
 Medicare

**Participant Contact Information**

Primary Phone \_\_\_\_\_  
 Alternate Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_

**Preferred Contact Method**  
 Primary Phone  Email  
 Alternate Phone  Text

**At which phone number can we text you?**  
 Primary  None  Alternate

**Household Information**

How many children live in your household? (Write the number of children for each age group.)

0-30 days	6-8 years
1-12 months	9-14 years
1-3 years	15-17 years
3-5 years	18-19 years

**Participant Sex (Choose One)**  
 Preconceptional Woman  Pregnant Woman  Interconceptional Woman  Male

Has no children and has never been pregnant?  Yes  No

**First Time Parent?**  Yes  No  
 (Does not matter if woman has children.)

**Are you a Parent?**  Yes  No  
 Does your child live w/ you?  Yes  No

**Age(s) of children needing services:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Did you or a family member have any of these issues when you tried to get healthcare in the past? (Select all that apply)**

<input type="checkbox"/> No insurance for myself	<input type="checkbox"/> No transportation
<input type="checkbox"/> No insurance for my children	<input type="checkbox"/> No childcare
<input type="checkbox"/> No money for co-pay	<input type="checkbox"/> Could not miss work
<input type="checkbox"/> Could not find a doctor	<input type="checkbox"/> No time
<input type="checkbox"/> Could not get an appointment	<input type="checkbox"/> Staff was rude
<input type="checkbox"/> Did not think going to the doctor was important	<input type="checkbox"/> Other _____

**Participant Consent**  
 I agree to provide the information above and to have it forwarded as a referral to available service agencies in the community. I agree to be contacted by the Improving Pregnancy Outcomes staff to follow up with me or the agency I referred I was referred to support my case.  
 Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Referral Agency \_\_\_\_\_ Date \_\_\_\_\_

**Program Use Only**  
 Date Pregnancy Test Given \_\_\_\_\_  
 Pregnancy Test Positive?  Yes  No

### Improving Pregnancy Outcomes Community Health Screening

PLEASE PRINT CLEARLY

**\* REQUIRED**

**Participant Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Referral \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_  
 Zip Code \_\_\_\_\_ County \_\_\_\_\_ Participant ID \_\_\_\_\_

**Referral Agency Information**

Referral Agency Name \_\_\_\_\_  
 Name of Person making the Referral \_\_\_\_\_ Phone \_\_\_\_\_  
 Outreach Type  Agency  Self  Door to Door  Event (specify) \_\_\_\_\_  Other \_\_\_\_\_

**Primary Language** (Choose one)  English  Spanish  Other \_\_\_\_\_

**Race** (Choose one)  Black  White  Asian  Other \_\_\_\_\_

**Ethnicity**  Hispanic  Yes  No  Multi-Race  Alaska/Pacific Islander  Other \_\_\_\_\_

**Health Insurance** (Check all that apply)  
 Medicaid/FIE  Commercial/Private  
 NJ Family Care  Uninsured/Self Pay  
 Medicare

**Participant Contact Information**

Primary Phone \_\_\_\_\_  
 Alternate Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_

**Preferred Contact Method**  
 Primary Phone  Email  
 Alternate Phone  Text

**At which phone number can we text you?**  
 Primary  None  Alternate

**Household Information**

How many children live in your household? (Write the number of children for each age group.)

0-30 days	6-8 years
1-12 months	9-14 years
1-3 years	15-17 years
3-5 years	18-19 years

**Participant Sex (Choose One)**  
 Preconceptional Woman  Pregnant Woman  Interconceptional Woman  Male

Has no children and has never been pregnant?  Yes  No

**First Time Parent?**  Yes  No  
 (Does not matter if woman has children.)

**Are you a Parent?**  Yes  No  
 Does your child live w/ you?  Yes  No

**Age(s) of children needing services:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Did you or a family member have any of these issues when you tried to get healthcare in the past? (Select all that apply)**

<input type="checkbox"/> No insurance for myself	<input type="checkbox"/> No transportation
<input type="checkbox"/> No insurance for my children	<input type="checkbox"/> No childcare
<input type="checkbox"/> No money for co-pay	<input type="checkbox"/> Could not miss work
<input type="checkbox"/> Could not find a doctor	<input type="checkbox"/> No time
<input type="checkbox"/> Could not get an appointment	<input type="checkbox"/> Staff was rude
<input type="checkbox"/> Did not think going to the doctor was important	<input type="checkbox"/> Other _____

**Participant Consent**  
 I agree to provide the information above and to have it forwarded as a referral to available service agencies in the community. I agree to be contacted by the Improving Pregnancy Outcomes staff to follow up with me or the agency I referred I was referred to support my case.  
 Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Referral Agency \_\_\_\_\_ Date \_\_\_\_\_

**Program Use Only**  
 Date Pregnancy Test Given \_\_\_\_\_  
 Pregnancy Test Positive?  Yes  No



# Printing Forms

49

## To print paper copies of the **Initial Contact Referral Form** and the **Community Health Screening Form**

From CHW Menu

- Click Forms
- Click **Initial Contact Referral Form**
- OR **IPO Community Health Screening Form**
- Move your cursor over the form in the PDF window
- Right-click the mouse
- Click Print
- Blank referral forms may be photocopied.

The screenshot displays the PRA|SPECT web application interface. On the left is a navigation menu with the following items: Home, User Administration, CHW Training, Initial Contact, Patients, Forms (highlighted with a red circle), Initial Contact Referral Form, IPO Community Health Screening Form, IPO Administration, and Logoff. The main content area shows a welcome message for 'Isaac' and a 'Generate Forms' section. Below this, there is a 'Please note' section and a 'Print options vary between operating systems, browsers, and browser versions.' section. A 'To print:' section lists instructions: 'Move your cursor over the form in the PDF window', 'Right-click mouse', and 'Select Print'. A note states 'You may print many copies of the same forms.' At the bottom, a PDF preview of the 'Initial Contact Referral Form' is shown, featuring fields for participant information, referral agency, and household details.

**PRA|SPECT**  
Perinatal Risk Assessment  
Single Point of Entry and Client Tracking System

Welcome, Isaac

**Generate Forms**

- Forms will display at the bottom of this page for printing
- For printing assistance, contact FHI at 856-665-6000

**Please note:** Initial Contact Forms and IPO Community Health Screening Forms. are not serialized. You can reuse, copy, or print multiple copies of the same forms.

Print options vary between operating systems, browsers, and browser versions.

**To print:**

- Move your cursor over the form in the PDF window
- Right-click mouse
- Select Print

You may print many copies of the same forms.

System Training Institute  
Referral Form

PLEASE PRINT CLEARLY

**REQUIRED**

**Participant Information**

Last Name First Name Date of Birth

Street Address City

Zip Code County Participant ID

**Referral Agency Information**

Referral Agency Name

Name of Person making the Referral Phone

Outreach Type  Agency  Self  Door to Door  Event (specify)  Other

**Primary Language**  Spanish  Other

**Race**  Black  White  Asian/Pacific Islander  Other

**Ethnicity**  Hispanic  Yes  No

**Health Insurance** (level of the visit)  Medicaid/PE  Commercial/Private  No Family Care  Uninsured/ief Pay  Medicare

**Referral Contact Information**

Referral Contact Method  Primary Phone  Email  Alternate Phone  Text

Primary Phone Alternate Phone

**Household Information**

How many children live in your household? (Write the number of children for each age group.)

0-30 days 0-4 years  
3-12 months 5-14 years  
1-2 years 15-17 years  
3-6 years 18-19 years

**Participant Has Children?**  Pregnant Woman  Interconceptional Woman  None

Previously pregnant and not currently pregnant?  Yes  No

Are you a Parent?  Yes  No

Has no children and has never been pregnant?  Yes  No

Does not matter if woman has children?  Yes  No

Are you a Parent?  Yes  No

Agency of children needing services?  Yes  No

Does not matter if agency?

# Notes

The image shows a sheet of lined paper with a purple header bar at the top. The page number '50' is located in a green box on the left side of the header. The main body of the page is filled with horizontal blue lines, and a vertical red line is positioned on the left side, creating a margin. The lines are evenly spaced and extend across the width of the page.



**WWW.PRASPECT.ORG**

WWW.PRASPECT.ORG

**Family Health Initiatives**  
**2500 McClellan Ave, Suite 270**  
**Pennsauken, NJ 08109**  
**856.665.6000**