



Was the family affected by Hurricane Sandy? (i.e. housing issues, loss of job/employment, displaced or having to relocate, etc.)  Yes  No

Is family Sandy Social Services Block Grant (SSBG) funded?  Yes  No  Unknown

**Pregnant Clients**

**Entry Into Prenatal Care**

\* Date of First Visit   -   -   \* LMP   -   -   \* EDD   -   -

Pre Pregnancy Weight (lbs)    Bleeding During Current Pregnancy  1st Trimester  2nd Trimester  3rd Trimester  None

**Identified Health Risks/Concerns** Has a doctor or other medical professional ever told you that you have any of the following conditions?

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

**\*4Ps Plus**

Did either of your parents have a problem with drugs or alcohol	<input type="radio"/> Yes <input type="radio"/> No	Have you ever drunk beer/wine/liquor	<input type="radio"/> Yes <input type="radio"/> No
Does your partner have any problem with drugs or alcohol	<input type="radio"/> Yes <input type="radio"/> No	In the month before you knew you were pregnant	<input type="radio"/> *Any <input type="radio"/> None
Have you ever felt manipulated by your partner	<input type="radio"/> Yes <input type="radio"/> No	how many cigarettes did you smoke	<input type="radio"/> <input type="radio"/>
Have you ever felt out of control or helpless	<input type="radio"/> Yes <input type="radio"/> No	how much beer/wine/liquor did you drink	<input type="radio"/> <input type="radio"/>
Over the past 2 weeks		how much marijuana did you use	<input type="radio"/> <input type="radio"/>
have you felt down, depressed or hopeless	<input type="radio"/> <input type="radio"/>		
have you felt little interest or pleasure in doing things	<input type="radio"/> <input type="radio"/>		

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

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

	Refer for Assessment		Prevention Education		No Referral Needed (did not drink/use drugs)
	Every Day	3-6 Days/wk	1-2 days/wk	<1 day/wk	
In the month before you knew you were pregnant					
About how many days a week <i>did you</i> usually drink beer / wine / liquor	<input type="radio"/>	<input type="radio"/>	<input 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 type="radio"/>
And now, about how many days a week <i>do you</i> usually drink beer / wine / liquor	<input type="radio"/>	<input type="radio"/>	<input 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 type="radio"/>

**Referrals/Education** Please complete for ALL clients

	Referred	Receiving Service	Referral Needed	Refused	Not Needed		Referred	Receiving Service	Referral Needed	Refused	Not Needed
Tobacco Cessation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Primary Care Participant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse Prevention Ed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Primary Care Child	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse Assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SSI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health Assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	DCP&P	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Domestic Violence Assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Preterm Labor Prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TANF/GA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes Care Program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency Assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Nutritional Consult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food Stamps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Breast Feeding Consult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Childbirth Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dentist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	*Community Based Services	<input type="radio"/>	na	na	<input type="radio"/>	<input type="radio"/>
Prenatal Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	* Includes referrals to local Community Health Worker, Community Home Visiting, and other supportive services.					

**PLEASE PRINT CLEARLY**

**Notes**

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**\* Participant Consent**  
 I agree to provide the information regarding my health and social service needs for review and screening in order to have appropriate available Community Based Services contact me. I agree to be contacted by program staff to follow-up with me or the agency to which I was referred.  
 Oral Consent Given  Yes  No  
 Sign here \_\_\_\_\_  
 Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.