



## STATE OF NEW JERSEY PERINATAL RISK ASSESSMENT First Visit Form

## **ALL FIELDS REQUIRED**

PLEASE PRINT CLEARLY

Date Form Completed SSN	Insurance ID/Me	edicaid #	Insu	rance Effective Date
Provider Information				
Chart #	Planned Delivery Site Code			
OTAL W	Sile code			
Patient Last Name	F	irst Name	Date of Bi	rth
<u>Information</u>				
Street Address		City	M M	D D Y Y
Zip Code County	Primary Phone			
County	Primary Priorie		Preferred Contact	O Text O Call
Engage of Control Name				O TOM O COM
Emergency Contact Name		Emerge	ncy Contact Phone	
			Ш <b>-</b> [ШД].	
Name of Father of the Baby		Father	of Baby Involved	O Yes O No
				O Yes O No
Race Ethnicity Hispanic O Yes Primar	ry Language Health Insurance	Medica	id MCO	
(Choose one) (Choose	one) (Select all that apply)	Medicare (Choose		
O Black O Native American O Eng O White O Multi-Racial Sna			_	edHealthcare Community
Asian Alaskan/Pacific Islander		Commercial/Private Amo	erigroup O Well izon NJ Health O Non	
Other Other	er (specify) O Medicaid MCO O	Uninsured/Self Pay O Hor	ZOITINJ HEAILIT O NOT	е
Entry Into Prenatal Care	Perinatal History First pregnancy? O Y	es O No If Yes, skip to Physical		<u>ssessment</u>
1ct Vicit	Date of last live birth	Date of last other pregnancy ou	tcome Blood Pres	ssure /
1st Visit			Dro Drogno	/ ancv Current
1st Visit	M M D D Y Y	M M D D	Pre Pregna Weight (lbs	
Under MCO	# Pregnancies Including Current	# Miscarriages < 20 v	/KS	
	# Previous Live Births	# Fetal Deaths ≥ 20 v	Height (ft in	nches)
LMP	# Live Births Now Living	# Induced Terminatio	ns	
M M D D Y Y	# Term Births ≥ 37 wks	# Ectopic or Molar Pr		Uring Current Pregnancy
EDD	# Preterm Births < 37 wks		O 1st Trim	
M M D D Y Y	# Previous Cesarean Sections		2nd Trir	mester O None
Infertility Treatment	lity enhancing drugs, artificial insemination or intra	uterine insemination	ssisted reproductive technol	logy (IVF, GIFT, ZIFT)
If No Skip to Pregnancy Risk [ ]	Taken by Mother [ ] Taken by Father [	] Insemination		
Pregnancy Risk Factors Current Pregnancy F	Prior Pregnancy	Current Prior Pregnancy Pregnancy		Current Prior Pregnancy Pregnancy
Y N Unk	YN	Y N Unk Y N		Y N Unk Y N
	O Fetal Reduction	O O O na na	Group B Strep	000 00
	Macrosomia Macrosomia	000 00	Urinary Tract Infection	O O O na na
	O O IUGR	00000	Hepatitis A	O O O na na
,	na na Oligo/Polyhydramnios	000 00	Hepatitis B	000 00
	<ul><li>Abnormal Amniocentesis</li><li>Abnormal AFP</li></ul>	000 00	Hepatitis C Alcohol Use	000 00
	Maternal Fetal Infection	000 00	Illicit Drug Use	000 00
	Abdominal Surgery	O O O na na	Opiate Dependence	000 00
	Fetal Genetic/Structural Abnorm		Opioid Replacement Tx	000 00
	O Rh Negative	O O O na na	Cats or Birds in Home	O O O na na
	na na Pyelonephritis	00000		
		PRA ID		16152





<b>ALL FIE</b>	LDS RI	EQUIRE
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Provider Chart #												

Current Medical Conditions/Risks																				
	Yes	No	Unk		Patient History			Yes	No	Unk	On Meds	Patient History				Yes	No	Unk		Patient History
Neurological Condition	0	0	0	O	O	Blood Dyscra	ısia	0	0	0	O	O		Congenital	Abnormalities		0	0	na	O
Seizures	Ŏ	Ŏ	Ö	Ö	Ö	Diabetes		Ŏ	Ŏ	Ö	Ŏ	Ö		Abnormal F		Ö	Ŏ	Ŏ	na	na
Depression/Mental Illness	Ŏ	Ŏ	Ŏ	Ŏ	Ö	Insulin Dependent		Ŏ	Ŏ	na	na	na		STD	'	Ŏ	Ŏ	Ŏ	0	0
Asthma	Ŏ	Ŏ	Ŏ	Ŏ	Ŏ	Thyroid Disease		Ŏ	Ŏ	0	0	0	Α	Allergies		Ŏ	Ŏ	Ŏ	Ŏ	Ŏ
Tuberculosis	Ö	Ö	Ö	Ŏ	Ö	Sickle Cell Tr		Ŏ	Ö	Ŏ	na	na			leeding Gums		Ŏ	Ŏ	Ö	na
Cystic Fibrosis	Ŏ	Ŏ	Ŏ	Ŏ	na	Sickle Cell Disease		Ŏ	Ŏ	Ŏ	0	na			Hand Smoke	Ŏ	Ŏ	Ŏ	na	na
Heart Condition	Ö	Ŏ	Ö	Ö	0	Liver Disease		Ŏ	Ö	Ö	Ö	0	H	Home Built	Before 1978	Ö	Ö	Ö	na	na
Chronic Hypertension	Ö	Õ	Ŏ	Ö	Ö	Renal Diseas		Ö	Ö	Ö	Ö	Ö	Г	Dental Visit	w/in the Year	Ö	Ö	Ó	na	na
Thalassemia	Ö	Ö	Ö	Ö	na	Lupus		Ö	Ö	Ö	Ö	na		HV Positive		Õ	0	0	0	na
Phlebitis/DVT	Ö	Ö	Ö	Ö	0	Cancer		ŏ	Ö	Õ	Ö	0		AIDS		Ŏ	ŏ	O	Ö	na
Anemia	0	Õ	Õ	Õ	Ö	Uterine Abno	rmalities	Õ	Ö	Õ	na	na		IIV Test Re	efused	Õ	õ	na	na	na
						0.011107.0110	· · · · · · · · · · · · · · · · · · ·				na					_	al Care	_	na	na
Psychosocial Risk Factors  Yes No Unk  Yes Yes Yes																				
Disabled O O	0	Nutritio	onal Co	ncerns	0.0	O Unem	ployed/Inade	equate l	Income	0	0 (	7 Tr	ansn	ortation	O In	suranc	e Enro	llment (	Delay	0
Homeless O	ŏ			egnanc		_	ind/Partner is		4			-	nanci			ouldn't				
Unstable Housing (	Ŏ			ression		$\sim$	quate Social		, ,	_			hild C	are Issues	_	naware				_
Transportation O	Ŏ		stic Viol		ŏŏ		itly in Foster			Ŏ	-	-		to Preg Te	-	bortion				_
Eating Disorder O	Ŏ	Educa	ition <12	2 Years	Ŏ Ŏ	Ŏ						Uı	nawa	re of Pregr						
Smoking/Tobacco Us	e													,	Cigaret	tes	Pac	:ks		
O Non Smoker	_	Н	ow mar	ny ciga	rettes OR	packs did yo	u smoke pe	er day i	in the	three n	nonths	s befor	e pre	egnancy?		] 0	R			
4Ps Plus						<u>Yes</u>	<u>No</u>								Yes	. No				
												, ,	"							
Did either of your parent					-		0	Have	e you	ever dr	unk b	eer/wir	ne/liq	uor	0	0				
Does your partner have any problem with drugs or alcohol																				
Have you ever felt mani	pulate	d by yo	our par	tner		0	0	In th	ie mor	ith befo	ore you	u knew	you	were pre	gnant <u>*<b>An</b>y</u>	<u>y Nor</u>	<u>1e</u>	chec	kea, inue v	vith
Have you ever felt out of	f conti	rol or h	elpless	S		0	0											the 4		vitti
Over the past 2 weeks									Н	ow mar	ny ciga	arettes	did y	ou smoke	e O	0			w-Up	
Have you felt dov	vn, de	presse	ed or ho	peless		0	0		Н	ow muc	ch bee	r/wine/	/liquo	or did you	drink O	0		Ques	tions	
Have you felt little		•					0							ou use	Ö	Ö	L			
4Ps Plus Follow-up Q												,		<u> </u>						
In the month be						ileckeu)		r for As			i			tion Educ				erral Ne		_
About how man				_			Every D	oay	3-6 Da	ays/Wk		1-2 D	ays/v	/VK <il< td=""><td>Day/Wk</td><td>Dia</td><td>NOT DI</td><td>ink/Us</td><td>e Drug</td><td>S</td></il<>	Day/Wk	Dia	NOT DI	ink/Us	e Drug	S
			/ liquor		uunj		0		(	C	1	(	$\circ$		0			0		
use	any d	rug sud	ch as m	narijuar	na, cocain	e or heroin	0		(	$\supset$	-	(	$\overline{C}$		0			0		
And now, about	how r	many c	days a v	week <i>a</i>	<i>lo you</i> us	ually														
drink	beer	/ wine	/ liquor				0			$\sim$			<u> </u>	İ	0			0		
use a	any dr	rug suc	ch as m	narijuan	a, cocain	e or heroin	0		(	$\supset$		(	$\circ$	i	0			0		
Referrals/Education		Referre	d Receiv Servic		erral Refu	sed Not Needed				Referred	Receiv Service		eferral eeded	Refused	Not M Needed	edicat	ions/(	Comm	<u>ents</u>	
Tobacco Cessation		0	Servic				Childbirth	Educat	tion	0	Servic		O	0	Needed					
Substance Abuse Preventio	n Ed	Ŏ	ŏ		Ó		Breastfeed			ŏ	Č		ŏ	Ŏ	ŏF					
Substance Abuse Assessme	_	Ŏ	Ŏ				Emergeno			Ŏ	Č		ŏ	Ŏ	Ŏ _					
Mental Health Assessment		Ŏ	Ŏ				TANF/GA	-		Ŏ	Č		Ŏ	Ŏ	ŏ			· <u> </u>		
Domestic Violence Assessm	nent	Ö	Ŏ				WIC			Ŏ	Č		Ŏ	Ŏ	ŏ -					
Diabetes Care Program		Ŏ	Ŏ				SSI			Ŏ	Č		Ŏ	Ŏ	Ŏ					
Preterm Labor Prevention		0	0				DCP&P			0	С		Ō	0	0					
Nutritional Consult		0	0				Food Stan	nps		0	C		Ō	0	0 _					
Community Based Services		0	na		а С		Dental Re	ferral		0	С		0	0	0					
* Includes referrals to local Com Home Visiting and other suppor	nmunity	Health V	Norker, C	Communit	ty										L					
поте увшту ана ошег ѕаррог	uve SEF	VICES																		





