42628

Patient Name

ALL FIELDS REQUIRED

PLEASE PRINT CLEARLY

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

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

1st Trimester HIV Specimen Information

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

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

3rd Trimester HIV Specimen Information

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

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

Source of HIV Information

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

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

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

Syphilis Serology Obtained? ○ Yes ○ No ○ Unknown

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

Prenatal Procedures *Select all that apply*

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

Fetal Ultrasound Performed? Yes ○ ○ No

If Yes, When?
○ 1st Trimester
○ 2nd Trimester
○ 3rd Trimester

Number of Ultrasounds __ __

Smoking/Tobacco Use

○ Non Smoker
If Non Smoker skip to 4Ps Plus

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

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

4Ps Plus

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

	Yes	No
Have you ever drunk beer/wine/liquor	○	○
In the month before you knew you were pregnant	*Any	None
How many cigarettes did you smoke	○	○
How much beer/wine/liquor did you drink	○	○
How much marijuana did you use	○	○

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

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

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

Referrals/Education

	Referred	Receiving Services	Referral Needed	Refused	Not Needed
Tobacco Cessation	○	○	○	○	○
Substance Abuse Prevention E	○	○	○	○	○
Substance Abuse Assessment	○	○	○	○	○
Mental Health Assessment	○	○	○	○	○
Domestic Violence Assessment	○	○	○	○	○
Diabetes Care Program	○	○	○	○	○
Preterm Labor Prevention	○	○	○	○	○
Nutritional Consult	○	○	○	○	○
Community Based Services*	○	na	na	○	○

	Referred	Receiving Services	Referral Needed	Refused	Not Needed
Childbirth Education	○	○	○	○	○
Breastfeeding Consult	○	○	○	○	○
Emergency Assistance	○	○	○	○	○
TANF/GA	○	○	○	○	○
WIC	○	○	○	○	○
SSI	○	○	○	○	○
DCP&P	○	○	○	○	○
Food Stamps	○	○	○	○	○
Dental Referral	○	○	○	○	○
Oral Health Education	○	○	○	○	○

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

Medications/Comments

PRA ID

PRA PLUS DO NOT PHOTOCOPY

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