42628

PERINATAL RISK ASSESSMENT
Third Trimester Form

Date Form Completed ☐☐ - ☐☐ - ☐☐ (M M - D D - Y Y)

ALL FIELDS REQUIRED

PLEASE PRINT CLEARLY

Provider Information

PRA OBGYN - *(Provider Address , Phone, Fax)*

Patient Information

Name _____ Date of Birth _____

Address _____ Primary Phone

_____ Provider Chart # _____

County _____ SSN# _____

New Information

Name _____ SSN# _____

Address _____

_____ County _____

Primary Phone _____ Preferred Contact ◯ Call ◯ Text

Prenatal Care

Planned Delivery Site Code ☐☐☐

# of prenatal care visits ☐☐

Date of last prenatal care visit ☐☐ - ☐☐ - ☐☐ (M M - D D - Y Y)

EDD ☐☐ - ☐☐ - ☐☐ (M M - D D - Y Y)

Current Pregnancy Risk Factors

	Y	N	Unk		Y	N	Unk
Toxoplasmosis	◯	◯	◯	CMV	◯	◯	◯
Listeria	◯	◯	◯	HPV	◯	◯	◯
Influenza	◯	◯	◯	Chlamydia	◯	◯	◯
Varicella Zoster	◯	◯	◯	Syphilis	◯	◯	◯
Rubella	◯	◯	◯	Gonorrhea	◯	◯	◯
Parvovirus	◯	◯	◯	Group B Strep	◯	◯	◯
West Nile Virus	◯	◯	◯	Trauma	◯	◯	◯
Lyme Disease	◯	◯	◯	Rh Sensitization	◯	◯	◯
Malaria	◯	◯	◯				

	Status Y	Status N		Status Y	Status N
Hyperemesis	◯	◯	Maternal Fetal Infection	◯	◯
Gestational Diabetes	◯	◯	Abdominal Surgery	◯	◯
Insulin Dependent	◯	◯	Fetal Genetic/Structural Abnorm	◯	◯
PIH/Preeclampsia	◯	◯	Pyelonephritis	◯	◯
Eclampsia	◯	◯	Urinary Tract Infection	◯	◯
Placenta Previa	◯	◯	Hepatitis A	◯	◯
Cervical Incompetence	◯	◯	Hepatitis B	◯	◯
Multiple Gestation	◯	◯	Hepatitis C	◯	◯
Macrosomia	◯	◯	Alcohol Use	◯	◯
IUGR	◯	◯	Illicit Drug Use	◯	◯
Oligo/Polyhydramnios	◯	◯	Opiate Dependency	◯	◯
Abnormal Amniocentesis	◯	◯	Opioid Replacement Tx	◯	◯
Abnormal AFP	◯	◯			

Current Medical Conditions/Risks

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

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

Current Psychosocial Risk Factors

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

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

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

Prenatal Vitamins

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

Blood Type

◯ A ◯ AB ◯ Negative
◯ B ◯ O ◯ Positive

Prenatal Fetal Diagnoses

Select all that apply

◯ Coarctation of the Aorta ◯ Double Outlet Right Ventricle ◯ Tricuspid Atresia ◯ Transp of Great Arteries ◯ Interrupted Aortic Arch ◯ Tetralogy of Fallot

◯ Total Anomalous Pulmonary Venous Return ◯ Ebstein Anomaly ◯ Hypoplastic Left Heart ◯ Truncus Arteriosus ◯ Pulmonary Atresia ◯ None of the above

◯ Other Cardiac Anomaly *Specify* _____ ◯ Other Non-Cardiac Anomaly *Specify* _____ ◯ Single Ventricle ◯ Unknown

PRA ID _____

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 Ed	○	○	○	○	○
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