STATE OF NEW JERSEY
PERINATAL RISK ASSESSMENT
Follow-up Form

ALL FIELDS REQUIRED

PLEASE PRINT CLEARLY

Date Form Completed (M M - D D - Y Y) | Medicaid ID | Insurance ID | Insurance Effective Date (M M - D D - Y Y)

Provider Information

Chart # | Planned Delivery Site Code | NPI | Group

Patient Information

Last Name | First Name | Date of Birth (M M - D D - Y Y)

Street Address | City

Zip Code | County | Primary Phone | Preferred Contact ◯ Text ◯ Call

Emergency Contact Name | Emergency Contact Phone

Name of Father of the Baby | Father of Baby Involved ..... ◯ Yes ◯ No | Married ..... ◯ Yes ◯ No

Race *(Choose one)*
◯ Black ◯ White ◯ Asian ◯ Native American ◯ Multi-Racial ◯ Alaskan/Pacific Islander ◯ Other

Ethnicity Hispanic ◯ Yes

Primary Language *(Choose one)*
◯ English ◯ Spanish ◯ Other *(specify)* _____

Health Insurance *(Select all that apply)*
◯ Medicaid PE ◯ Medicaid FFS ◯ Medicaid MCO ◯ Medicare ◯ NJ Family Care ◯ Commercial/Private ◯ Uninsured/Self Pay

Medicaid MCO *(Choose one)*
◯ Aetna Better Health ◯ Amerigroup ◯ Horizon NJ Health ◯ UnitedHealthcare Community ◯ WellCare ◯ None

Entry Into Prenatal Care

1st Visit (M M - D D - Y Y)
1st Visit Under MCO (M M - D D - Y Y)
LMP (M M - D D - Y Y)
EDD (M M - D D - Y Y)

Perinatal History

First pregnancy? ◯ Yes ◯ No *If Yes, skip to Physical Assessment*

Date of last live birth (M M - D D - Y Y)
Date of last other pregnancy outcome (M M - D D - Y Y)

_____ # Pregnancies Including Current
_____ # Previous Live Births
_____ # Live Births Now Living
_____ # Term Births ≥ 37 wks
_____ # Preterm Births < 37 wks
_____ # Previous Cesarean Sections
_____ # Miscarriages < 20 wks
_____ # Fetal Deaths ≥ 20 wks
_____ # Induced Terminations
_____ # Ectopic or Molar Pregnancies

Physical Assessment

Blood Pressure ___ / ___
Pre Pregnancy Weight (lbs)
Current Weight (lbs)
Height (ft-inches) ___ - ___

Bleeding During Current Pregnancy
◯ 1st Trimester ◯ 3rd Trimester ◯ 2nd Trimester ◯ None

Infertility Treatment

If No Skip to Pregnancy Risk

◯ No ◯ Fertility enhancing drugs, artificial insemination or intrauterine insemination ◯ Assisted reproductive technology (IVF, GIFT, ZIFT)
[ ] *Taken by Mother* [ ] *Taken by Father* [ ] *Insemination*

Pregnancy Risk Factors

	Current Pregnancy Y	N	Unk	Prior Pregnancy Y	N
Low Birth Weight (≤ 2500gm)	na	na	◯	◯	◯
History of PROM	na	na	◯	◯	◯
Hyperemesis	◯	◯	◯	◯	◯
Obesity	◯	◯	◯	na	na
Gestational Diabetes	◯	◯	◯	◯	◯
Insulin Dependent	◯	◯	na	◯	◯
PIH/Preeclampsia	◯	◯	◯	◯	◯
Eclampsia	◯	◯	◯	◯	◯
Placenta Previa	◯	◯	◯	◯	◯
Cervical Incompetence	◯	◯	◯	◯	◯
Multiple Gestation	◯	◯	◯	na	na

	Current Pregnancy Y	N	Unk	Prior Pregnancy Y	N
Fetal Reduction	◯	◯	◯	na	na
Macrosomia	◯	◯	◯	◯	◯
IUGR	◯	◯	◯	◯	◯
Oligo/Polyhydramnios	◯	◯	◯	◯	◯
Abnormal Amniocentesis	◯	◯	◯	◯	◯
Abnormal AFP	◯	◯	◯	◯	◯
Maternal Fetal Infection	◯	◯	◯	◯	◯
Abdominal Surgery	◯	◯	◯	na	na
Fetal Genetic/Structural Abnorm	◯	◯	◯	◯	◯
Rh Negative	◯	◯	◯	na	na
Pyelonephritis	◯	◯	◯	◯	◯

	Current Pregnancy Y	N	Unk	Prior Pregnancy Y	N
Group B Strep	◯	◯	◯	◯	◯
Urinary Tract Infection	◯	◯	◯	na	na
Hepatitis A	◯	◯	◯	na	na
Hepatitis B	◯	◯	◯	◯	◯
Hepatitis C	◯	◯	◯	◯	◯
Alcohol Use	◯	◯	◯	◯	◯
Illicit Drug Use	◯	◯	◯	◯	◯
Opiate Dependence	◯	◯	◯	◯	◯
Opioid Replacement Tx	◯	◯	◯	◯	◯
Cats or Birds in Home	◯	◯	◯	na	na

Serial | PRA ID

DO NOT PHOTOCOPY BLANK FORMS

DO NOT FAX FORMS

Draft

ALL FIELDS REQUIRED

Provider Chart #

Current Medical Conditions/Risks

	Yes	No	Unk	On Meds	Patient History		Yes	No	Unk	On Meds	Patient History		Yes	No	Unk	On Meds	Patient History
Neurological Condition	○	○	○	○	○	Blood Dyscrasia	○	○	○	○	○	Congenital Abnormalities	○	○	○	na	○
Seizures	○	○	○	○	○	Diabetes	○	○	○	○	○	Abnormal Pap Smear	○	○	○	na	na
Depression/Mental Illness	○	○	○	○	○	*Insulin Dependent*	○	○	na	na	na	STD	○	○	○	○	○
Asthma	○	○	○	○	○	Thyroid Disease	○	○	○	○	○	Allergies	○	○	○	○	○
Tuberculosis	○	○	○	○	○	Sickle Cell Trait	○	○	○	na	na	Sensitive/Bleeding Gums	○	○	○	○	na
Cystic Fibrosis	○	○	○	○	na	Sickle Cell Disease	○	○	○	○	na	2nd or 3rd Hand Smoke	○	○	○	na	na
Heart Condition	○	○	○	○	○	Liver Disease	○	○	○	○	○	Home Built Before 1978	○	○	○	na	na
Chronic Hypertension	○	○	○	○	○	Renal Disease	○	○	○	○	○	Dental Visit w/in the Year	○	○	○	na	na
Thalassemia	○	○	○	○	na	Lupus	○	○	○	○	na	HIV Positive	○	○	○	○	na
Phlebitis/DVT	○	○	○	○	○	Cancer	○	○	○	○	○	AIDS	○	○	○	○	na
Anemia	○	○	○	○	○	Uterine Abnormalities	○	○	○	na	na	HIV Test Refused	○	○	na	na	na

Psychosocial Risk Factors

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

Reason for Late Entry to Prenatal Care

	Yes		Yes
Transportation	○	Insurance Enrollment Delay	○
Financial	○	Couldn't Find a Health Provider	○
Child Care Issues	○	Unaware of Importance of PNC	○
Access to Preg Test	○	Abortion Desired/Unsuccessful	○
Unaware of Pregnancy	○		

Smoking/Tobacco Use

○ Non Smoker

How many cigarettes OR packs did you smoke per day in the three months before pregnancy?

Cigarettes ☐☐ OR Packs [0]

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		Referred	Receiving Services	Referral Needed	Refused	Not Needed
Tobacco Cessation	○	○	○	○	○	Childbirth Education	○	○	○	○	○
Substance Abuse Prevention Ed	○	○	○	○	○	Breastfeeding Consult	○	○	○	○	○
Substance Abuse Assessment	○	○	○	○	○	Emergency Assistance	○	○	○	○	○
Mental Health Assessment	○	○	○	○	○	TANF/GA	○	○	○	○	○
Domestic Violence Assessment	○	○	○	○	○	WIC	○	○	○	○	○
Diabetes Care Program	○	○	○	○	○	SSI	○	○	○	○	○
Preterm Labor Prevention	○	○	○	○	○	DCP&P	○	○	○	○	○
Nutritional Consult	○	○	○	○	○	Food Stamps	○	○	○	○	○
Community Based Services*	○	na	na	○	○	Dental Referral	○	○	○	○	○

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

Medications/Comments

Serial

PRA ID

DO NOT PHOTOCOPY BLANK FORMS

DO NOT FAX FORMS