|  |  |
| --- | --- |
| **CPSP Integrated Initial and & Trimester Assessments and Individualized Care Plan**  3  2  I  **Client Orientation:**  ❑ Client orientation per protocol ❑States understands **Welcome to Pregnancy Care** ❑ States understands CPSP is voluntary and agrees to participate ❑Reviewed STT HE, **Pregnant?** **Steps for a Healthy Baby** ❑Vitamins per protocol  Minutes: Signature:  Date of Orientation:  Document additional Orientation in Progress Note | Client Identifier |
| **Pregnancy Information**  DOB: Age:  EDD: Weeks Gestation | Grav: Para: TAB: SAB:  **OB problem list reviewed, if available, before conducting assessments.**  ❑1st TM ❑2nd TM ❑3rd TM |

**Assessment: Complete all items regardless of which trimester client begins care**

**Psychosocial:**

| **Psychosocial Needs/Risks/Concerns** *(ask questions in*  *Initial, 2nd or 3rd trimester as indicated)* | **Psychosocial Individualized Care Plan Developed with Client** | **Com-ment** |
| --- | --- | --- |
| 1. Is this a planned pregnancy? ❑Yes ❑ No, describe:   I   1. Is this a wanted pregnancy? ❑Yes ❑ No, describe:      1. Are you considering abortion/adoption? ❑No   ❑ Yes, describe: | ❑ Client states she understands STT PSY, ❑ **Uncertain about**  **Pregnancy,**❑ **Choices**  ❑ Client goal/plan:  ❑ Informed of CA Safe Surrender Law  ❑ Consult with OB provider  ❑ Referred to/for: |  |
| 1. How does the FOB/Partner feel about the pregnancy? ❑ Happy ❑ Involved ❑ Upset ❑ FOB/Partner not sure ❑ Uninvolved   ❑ FOB/Partner doesn’t know ❑ Client doesn’t know how partner feels  I  ❑ Client wishes more support, identified sources: | ❑ Referred to/for:  ❑ Client goal/plan: |  |
| What are your goals for this pregnancy?: ❑ healthy baby  I  ❑ other: | ❑ Referred to/for:  ❑ Client goal/plan: |  |
| Have you had issues with previous pregnancies? ❑ N/A  I  ❑ No ❑ Yes, describe:  ❑ Would you like information on how to reduce risk in this pregnancy? ❑Yes ❑ No | ❑ Client goal/plan:  ❑ Consult with OB provider |  |
| Have you had a previous pregnancy loss/infant death?  I  ❑No ❑ Yes, describe: | ❑ Client goal/plan:  ❑ Client states aware of support resources  ❑ Referred to/for: |  |
| Members of household (not including client)  Number of adults:  I  Relationship to client:  Number of children:  Relationship to client:  Do all of your children live with you? ❑ N/A ❑ Yes  ❑ No, describe: | ❑ Client goal/plan:  ❑ Referred to/for |  |
| 1. Are you currently receiving services from a local agency such as case management, home visiting, counseling etc.?  ❑ No ❑Yes, describe:   I | ❑ Client goal/plan:  ❑ Obtained client’s written permission to share information with:  Agency:  Contact person:  Phone: Fax: |  |
| ❑ No ❑ Yes, describe:  2 | ❑ Client goal/plan:  ❑ Obtained client’s written permission to share information with:  Agency:  Contact person:  Phone: Fax: |  |
| ❑ No ❑ Yes, describe:  3 | ❑ Client goal/plan:  ❑ Obtained client’s written permission to share information with:  Agency:  Contact person:  Phone: Fax: |  |
| 1. Have you ever seen a counselor for personal or family issues or support? ❑ No ❑ Yes, describe:   I  Do you need counseling now? ❑ No ❑ Yes, describe: | ❑ Client goal/plan:  ❑ Referred to/for: |  |
| 1. Have you ever been emotionally, physically, or sexually abused by a partner or someone close to you?   ❑ No ❑ Yes, describe:  I     1. Within the last year, have you ever been hit, slapped, kicked, pushed, shoved, forced to have sex, forced to get pregnant or otherwise physically hurt by your partner or ex-partner? ❑ No ❑Yes, by whom?   Do you have injuries now? ❑ No ❑ Yes, describe:  Do you feel in danger now? ❑ No ❑ Yes, describe: | ❑ Client Goal/plan:  ❑ States understands STT PSY **Cycle of Violence**  ❑ Made safety goal/plan ❑ Client states understands legal options ❑ Agrees to follow STT PSY: **Safety When Preparing to Leave**  ❑ Referred to/for:  ❑ If minor, completed mandated report, date:\_\_\_\_\_\_\_\_  ❑ If current injuries/adult, reported to OB provider  ❑ Reported to law enforcement, date:\_\_\_\_\_\_\_\_\_  ❑ In contact with law enforcement/agency already: |  |
| 1. Are you afraid of your partner or ex-partner? ❑ No ❑ Yes, describe:   I  2  ❑ No ❑ Yes, describe:  3  ❑ No ❑ Yes, describe: | ❑ Client goal/plan: states understands:  ❑STT PSY **Cycle of Violence**  ❑ What to do in an emergency ❑ Legal options. ❑ Agrees to follow STT PSY: **Safety When Preparing to Leave**  ❑ Made safety plan  ❑ Referred to/for:  Update:  Update: |  |
| 1. Are you having any other personal or family challenges? ❑ No ❑ Yes, describe:   I  ❑ No ❑ Yes, describe:  2  ❑ No ❑ Yes, describe:  3 | ❑ Client states aware of support resources:  ❑ Client goal/plan:  ❑ Referred to/for:  ❑ Update:  ❑ Update: |  |
| 1. Who do you turn to for emotional support?   ❑ FOB/partner ❑ family member:  I  ❑ friend: ❑ other:  ❑ No one, describe:  2  ❑ No one, describe:  3  ❑ No one, describe: | ❑ Client identified possible sources of support  ❑ Client goal/plan:  ❑ Referred to/for:    ❑ Update:  ❑ Update: |  |
| 1. Do you often feel down, sad or hopeless? ❑No   I  ❑ Yes, describe:   Do you often feel irritable, restless or anxious? ❑No  ❑ Yes, describe:  Have you lost interest or pleasure in doing things that you used to enjoy? ❑ No ❑ Yes, describe:  Ask the above questions, describe response:    3  2  Ask the above questions, describe response: | ❑ Screen for signs of emotional concerns at future appointments  ❑ Referred to ❑provider or ❑psychosocial consultant for assessment and intervention  ❑ Client goal/plan:  ❑ Referred to:  Update:    Update: |  |
| 1. Did your parents use alcohol or drugs? ❑No ❑ Yes, describe:   I   1. Does your partner use alcohol or drugs? ❑ N/A ❑No   ❑ Yes, describe: | ❑ Client states understands risks ❑ Client goal/plan:  ❑ Referred to/for: |  |
| 1. Before you knew you were pregnant, how much beer/wine/liquor did you drink? ❑ None   I  ❑ was drinking a day/wk./month  amount type of alcohol  Are you drinking now? ❑ No ❑ Yes, describe:  a day/wk./month  amount type of alcohol  Do you drink a lot at one time? (4 or more drinks in  about 2 hours) ❑ No ❑ Yes : a day/wk./month  times | ❑ Client states understand risks ❑ Client goal/plan:  ❑ Follow STT PSY, **Baby Can’t Say No**  ❑Follow STT PSY, **Drugs and Alcohol, when you want to STOP using**  ❑ Client states decided not to drink alcohol  ❑ Agreed to cut down to how much: \_\_\_\_\_\_  Client stated confidence in quitting/cutting down:  (circle): 1 2 3 4 5 6 7 8 9 10  ❑ Support person:  ❑ Consult with OB provider  ❑ Referred to/for: |  |
| 2  Are you drinking now? ❑ No ❑ Yes, describe:  a day/wk./month  amount type of alcohol  Do you drink a lot at one time? (4 or more drinks in  about 2 hours) ❑ No ❑ Yes : a day/wk./month  times | Update: |  |
| 3  Are you drinking now? ❑ No ❑ Yes, describe:  a day/wk./month  amount type of alcohol    Do you drink a lot at one time? (4 or more drinks in  about 2 hours) ❑ No ❑ Yes : a day/wk./month  times | Update: |  |
| 1. Before you knew you were pregnant, how much tobaccodid you smoke (including e-cigarettes)? ❑None   I  ❑ was smoking (amount, type, how often) \_\_\_\_\_\_  Are you smoking now? ❑ No  ❑ Stopped smoking and is not smoking now  ❑ Cut down to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Smoking about the same amount | ❑ Client states understands risks ❑ Client goal/plan:  ❑ Will cut down to how much  ❑ Will quit when  ❑Client’s confidence in quitting (circle):  1 2 3 4 5 6 7 8 9 10  ❑ Identified support person:  ❑ States understands STT HE: **You can Quit Smoking**  ❑ Referred to CA Smokers’ Helpline 1-800-NoButts  ❑ Consult with OB provider  ❑ Referred to/for: |  |
| Are you smoking now? ❑Yes ❑ No  2  ❑ Stopped smoking and is not smoking now  ❑ Cut down to  ❑ Smoking about the same amount | Update: |  |
| 3  Are you smoking now*?* ❑Yes ❑ No  ❑ Stopped smoking and is not smoking now  ❑ Cut down to  ❑ Smoking about the same amount | Update: |  |
| 1. Do people smoke around you? ❑ No   I  ❑ Yes, about hours per day  Number  2  ❑ No ❑ Yes, about hours per day  Number  3  ❑ No ❑ Yes, about hours per day  Number | Client goal/plan:  ❑ States will avoid smoke  ❑ States will talk to others about keeping home and car smoke-free ❑ Discussed STT HE section, *Second Hand Smoke*❑ **You can Quit Using Drugs or Alcohol**   * Update: * Update: |  |
| 1. Before you knew you were pregnant, how much did you usually use marijuana or other drugs? ❑ None   I  ❑ Was using: a day/wk./month  amount drug  Are you using drugs now? ❑ No  ❑ Yes, now using: a day/wk./month  amount drug | ❑ Client verbalizes understanding of risks. Client goal/plan:  ❑Client understands STT HE: **You can Quit Using Drugs or Alcohol**  ❑ Has decided to: ❑ cut down to how much\_\_\_\_\_\_\_\_  ❑ not to use any drugs ❑ Client’s confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10  ❑ Support person:  ❑ Consult with OB provider ❑ Referred to/for:  ❑ Obtained client’s written permission to exchange information with: Agency:  Contact person:  Phone: Fax: |  |
| Are you using drugs now? ❑ No  2  ❑ Yes, using: a day/wk./month  amount drug | Update: |  |
| Are you using drugs now? ❑No  ❑ Yes, now using: a day/wk./month  3  amount drug | Update: |  |
| 1. What is your source of financial support?   ❑ Self, type of work:  ❑ FOB/partner, type of work:  ❑ Family member/ friend:  ❑ CalWORKS ❑ SSI ❑ other:  I  ❑ Concerns, describe:  ❑ Concerns, describe:  2  3  ❑ Concerns, describe: | ❑ Client Goal/plan:  ❑ Referred to/for:    Update:  Update: |  |
| 1. Where do you live?  ❑ Apartment/house ❑ other:  ❑ Concerns, describe:   I  2  ❑ Concerns/changes, describe:  3  ❑ Concerns/changes, describe: | ❑ Client Goal/plan:  ❑ Referred to/for:  Update:  Update: |  |
| 1. Any other questions or concerns?   ❑ None❑ Yes, describe:  I  2  ❑ None❑ Yes, describe:  ❑ None❑ Yes, describe:  3 | ❑ Client Goal/plan:  ❑ Referred to/for:  Update:  Update: |  |
| 1. Discussed results of assessment with client and client identified the following strengths:   I  2  3 | | |
| **Psychosocial**  I  Minutes spent Completed by:  Signature Title Date  Signature of medical provider *if assessor is CPHW*:  Signature Title Date  2  Minutes spent Completed by:  Signature Title Date  3  Minutes spent Completed by  Signature Title Date | | |

**Health Education**

| **Health Education Learning Needs/Risks/Concerns** (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell) | **Health Education Individualized Care Plan**  **Developed with Client** | **Com-ment** |
| --- | --- | --- |
| 1. How do you like to learn?: ❑ Text message reminders   ❑ Reading/handouts ❑ Classes/groups  I  ❑ Individual teaching ❑ Videos  ❑ Other:  How well do you write/read? ❑ good/fair ❑ poor/non-reader   1. Do you have someone you can talk to about what we discussed today? ❑ Yes, identify ❑ No | ❑ Will use following learning methods: ❑ Client wishes adapted education methods, such as using pictures or low literacy materials ❑ Will sign up for Text4Baby  ❑ Client stated she will involve a support person by sharing educational materials after her appointmentsName/relationship: |  |
| 1. What language do you prefer to speak?   What language do you prefer to read? \_\_\_\_\_\_\_\_\_\_\_\_\_  In what language would you like materials?\_\_\_\_\_\_\_\_\_\_\_\_\_  I | ❑ Provide materials in \_\_\_\_\_\_\_\_\_\_\_\_\_language. |  |
| 1. What was the last grade you completed?   ❑ Less than high school/GED  I | ❑ Referred to: |  |
| 1. How long have you lived in this area? ❑ More than a year   ❑ Less than one year  Do you plan to stay in this area for the rest of your pregnancy? ❑ Yes ❑ No, comments:    Do you know how to get other health care services?  I  ❑Yes ❑ No, comments: | ❑ Client verbalizes understanding of available health care services  ❑Provide a copy of her medical records if she needs to leave the area.  ❑ Referred to: |  |
| 1. Do you have any physical difficulties that affect learning? (Such as vision, hearing, learning disabilities)? ❑No   I  ❑ Yes, describe: | ❑ Client wishes adapted health education methods  ❑ Consult with OB provider  ❑ Referred to/for: |  |
| 1. Who gives you advice about your pregnancy? ❑ No one ❑ mother ❑ mother-in-law ❑ grandmother ❑ partner ❑ sister ❑ friend: ❑ other:   I  What are the most important things they have told you? | ❑ Referred to support group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Client stated she will consult with OB provider regarding the following possibly harmful advice: |  |
| 1. Are you exposed to any of the following at work or home?   I  ❑ chemicals, fumes, pesticides, lead  ❑ cats ❑ rodents ❑ douching  ❑ hot baths ❑ x-rays ❑ other:  ❑ No, none of the above | Client goal/plan: ❑ Follow STT HE **Pregnant? Steps for a Healthy Baby** ❑**Keep Safe at Work**  ❑ Consult with OB provider re:  ❑ Client has MotherToBaby California information  (866) 626-6847 [www.mothertobabyca.org](http://www.mothertobabyca.org)  ❑ Mailed or faxed MotherToBaby client referral form |  |
| 1. We ask all clients this question: do you have any of these risk factors for diseases like chlamydia, gonorrhea, herpes, or HIV?   More than one sexual partner?  Ever had sex while using alcohol or drugs?   Have you or any partners ever had an STD?   Has your partner had sex with anybody else?  Have you or any partners exchanged sex for drugs, money, or shelter?  Have you or any partners ever injected drugs not prescribed by a doctor? | ❑ Client agrees to follow STT HE ❑ **What you Should Know about STDs** ❑**What you should Know about HIV**  ❑**You Can Protect Yourself and Your Baby from HIV**  ❑Referred to: |  |
| 1. Which of the following topics would you like to learn about?   I  ❑ Body changes during pregnancy, ❑ Baby’s growth,  ❑ Immunizations for pregnant women (flu, Tdap)  ❑ other topics, describe:  ❑ None, follow up at next visit  ❑ No, follow up at next visit ❑ Yes, describe topics:  2  ❑ No , follow up at next visit ❑ Yes, describe topics:  3 | ❑ Reviewed the following items with client:  ❑ Client will discuss the following with OB provider:  ❑ Reviewed the following items with client:  ❑ Client will discuss the following with OB provider:  ❑ Reviewed the following items with client:  ❑ Consult with OB provider re: |  |
| 1. Have you had a dental check-up in the past 12 months?   I  Date: ❑ No:    Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe:  Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe: :  2  *If referred: Have you seen a dentist? Date:*  Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe:  3  *If referred: Have you seen a dentist? Date:* | Client Goal/plan: Follow STT HE ❑ **Prevent Gum Problems**❑ **See a Dentist** ❑ **Keep Teeth Healthy** ❑ Consult with OB provider❑ Completed Prenatal Dental Referral, date: \_\_\_\_\_\_\_\_\_\_\_  ❑ Referred to/for:  ❑ Update:  ❑ Update: |  |
| 1. How will you come for appointments?   ❑ bus ❑ car ❑ walk ❑ other:  ❑ Any transportation issues? Describe:  2  I  ❑ Any transportation issues? Describe:   ❑ Any transportation issues? Describe:  3 | ❑ Client goal/plan:  ❑ Client goal/plan:  ❑ Client goal/plan: |  |
| 1. Do you know how to use a seat belt when pregnant?   I  ❑ Yes ❑ No  Do you always use a seat belt?  2  ❑ Yes ❑ No  Do you always use a seat belt?  ❑ Yes ❑ No  3 | ❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby**  ❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby**  ❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby** |  |
| 1. Can you describe what you think might be pregnancy danger signs, symptoms of preterm labor, labor induction, and when to call the doctor for prenatal concerns?  ❑ Yes ❑ No, list gaps:    Discussed above items: ❑ Yes ❑ No, list gaps:   I  2  Discussed above items ❑ Yes ❑ No, list gaps:  3 | Client goal/plan: Follow: STT HE ❑ **Danger Signs in Welcome to Pregnancy Care** ❑ **If Labor Starts Too Early**  ❑ **What You Need to Know About Labor Induction**  ❑ Consult with OB provider  Client goal/plan: Follow: STT HE ❑ **Danger Signs** **in Welcome to Pregnancy Care** ❑ **If Labor Starts Too Early**  ❑ **What You Need to Know About Labor Induction**  ❑ Consult with OB provider  Client goal/plan: ❑ Client is more than 28 weeks and will follow ❑ STT HE **Kick Counts**❑ **Danger Signs in Welcome to Pregnancy Care**❑ **If Labor Starts Too Early**  ❑ **What You Need to Know About Labor Induction**  ❑ Consult with OB provider |  |
| 1. What are your plans for labor and delivery?   3  labor support person ❑ Yes ❑ No  signs of labor, when to call ❑ Yes ❑ No  goal/plans for transportation to hospital ❑ Yes ❑ No  childcare goal/plans for other kids ❑ Yes ❑ No   1. Do you have any questions about how to take care of yourself after delivery? ❑ No ❑ Yes, describe:   ❑ Discussed importance of postpartum care, procedure for making appointments. | ❑ Referred to hospital tour: Name of hospital:  ❑ Referred to childbirth preparation class  ❑ Understands options for labor and delivery  ❑ Reviewed/completed STT NUT **My Birth Plan**  ❑ Client understands signs of labor, when to call  ❑ Client has support person:  ❑ Client has made arrangements for transportation to hospital ❑ Client has made arrangements for childcare for other kids  ❑ Client has no support person—notified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Client understands importance of postpartum care and has agreed to make appointment |  |
| 1. Do you know about infant: ❑ care, 🞏safety, 🞏 illness,   3  🞏 safe sleep, 🞏 immunizations?   1. Do you have the following items?   ❑ baby supplies/clothing/safe sleeping  ❑ child passenger safety seat  ❑ Child care, if returning to work or school  ❑Needs: | Client Goal/plan: Follow: STT HE  ❑ **Keep Your New Baby Safe and Healthy**  ❑ **When Newborn is Ill**  ❑ **Baby Needs Immunization**  ❑ If multiples, **Getting Ready for Multiples, Baby Products, Discounts, and Coupons**  ❑ Client has car seat/understands car seat requirements  ❑ Client understands crib safety (crib slats no more than 2 3/8 inches apart and other tips)  ❑ Advised to call:  ❑ Referred to/for: |  |
| 1. Have you chosen a doctor for the baby? ❑ Yes ❑ No   3  Name of provider | ❑ Referred to pediatric provider:  ❑ Referred to CHDP provider: |  |
| 1. Do you plan to have more children? ❑ Yes ❑ No   How many? \_\_\_\_\_  3  How far apart?  What birth control method(s) are you interested in?  Do you have any concerns about your ability to use birth control? ❑ No ❑ Yes, describe:  ❑ Remembering to use birth control  ❑ Concerned about failure  ❑ Partner interferes with birth control | ❑ Has family planning provider  ❑ Discussed birth control methods, including long acting contraceptives (LARCs)  ❑ Preferred contraceptive method:  ❑ Referred to family goal/planning provider  ❑ Client will consult with obstetric provider if planning to get pregnant again before this baby is 18 months old.  ❑ Client will consult with OB provider if client’s partner does not support her use of birth control.  ❑ Client understands there are methods partner does not have to know about. |  |
| 1. Do have a doctor you can go to for regular medical checkups? ❑ Yes Name:   3  ❑ No | ❑ Client will call: Name:  ❑ Referred to/for: |  |
| 1. Do you have health insurance for care after your pregnancy*?* ❑ Yes ❑ No   3 | ❑Referred to eligibility worker, Covered CA or safety net |  |
| 1. Has your doctor told you that you have any health problems that need follow up after your pregnancy? *(diabetes, high blood pressure, obesity, depression etc.)* ❑No ❑ Yes, describe:   3 | Client goal/plan:  ❑Make appointment with primary care provider  ❑ Referred to/for: |  |
| 1. Do you have any other questions or concerns? ❑ No ❑ Yes, describe:   I  2  ❑ No ❑ Yes, describe:    3  ❑ No ❑ Yes, describe: | Client goal/plan:  Client goal/plan:    Client goal/plan: |  |
| 1. Reviewed health education assessment with client and client identified the following strengths:   I  2  3 | |  |
| **Health Education:**  I  Minutes spent Completed by:  Signature Title Date  Signature of medical provider *if assessor is CPHW*:  Signature Title Date  2  Minutes spent Completed by:  Signature Title Date  3  Minutes spent Completed by  Signature Title Date | | |

**Nutrition**

| **Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated) | **Nutrition Individualized Care Goal/plan Developed with Client** | **Com-ment** |
| --- | --- | --- |
| **Anthropometric: Height, Weight, & Body Mass Index (BMI)** | | |
| Pre-pregnancy weight: lbs. Height\_\_\_\_\_\_BMI\_\_\_\_\_\_\_  I  BMI category/Weight Gain Grid used:  ❑ Underweight ❑ Normal ❑ Overweight ❑ Obese  ❑ Currently pregnant with multiples?  ❑ Twins ❑ Triplets or more (consult w/ provider for wt. gain goal)  During previous pregnancy how much weight did you gain? \_\_\_\_\_\_\_\_lbs. ❑N/A | *Client states understanding of:*  ❑ Pre-pregnancy weight category (BMI)  ❑ Recommended weight gain range for pre pregnancy weight category is between lbs. and lbs.  ❑ Plotting and discussing weight gain at every visit  ❑ Client’s weight gain goal for this pregnancy:  ❑ Referred to RD (date):  ❑ Referred to (profession and date): |  |
| Current weight gain:­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_lbs  ❑ Appropriate ❑ Excessive ❑ Inadequate  I  How do you feel about the weight you have gained so far with this pregnancy?  What questions do you have about your weight gain during pregnancy?  Current weight gain:  2  ❑ Appropriate ❑ Excessive ❑ Inadequate  How do you feel about the weight you have gained so far with this pregnancy?  Current weight gain:  3  ❑ Appropriate ❑ Excessive ❑ Inadequate  How do you feel about the weight you have gained so far with this pregnancy? | ❑Discussed plotting and reviewing weight gain at every visit  Client agrees to follow STT NUT handout(s) (indicate date):  ❑ **Tips To Gain Weight** ❑ **Tips to Slow Weight Gain**  ❑ Referred to RD (date):  ❑ Referred to/date:  ❑ Client will:  ❑ Referred to RD (date):  ❑ Referred to/date:  ❑ Client will:  ❑ Referred to RD (date):  ❑ Referred to/date:  ❑ Client will: |  |
| **Biochemical: Lab Values** | | |
| Consult with provider regarding whether there are abnormal lab values and treatment prescribed.  I  HGB HCT  Fasting Blood Glucose\_\_\_\_\_\_\_\_\_ Date of consultation with provider\_\_\_\_\_\_\_\_\_\_\_  Abnormal lab values: ❑ No ❑ Yes, Explain:  2  Consult with provider regarding whether there are abnormal lab values and treatment prescribed.  Fasting Blood Glucose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of consultation with provider:  Abnormal lab values: ❑ No ❑ Yes, Explain:  3  Consult with provider regarding whether there are abnormal lab values and treatment prescribed.  Fasting Blood Glucose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of consultation with provider:  Abnormal lab values: ❑ No ❑ Yes, Explain: | If approved by provider, review with client:  Client agrees to follow STT N handout(s) (indicate date):  ❑ **Get the Iron You Need**  ❑ **If You Need Iron Pills**  ❑**Iron Tips\_\_\_\_\_\_\_**❑**Iron Tips: Take Two\_\_\_\_\_\_\_**  ❑**My Action Plan for Iron\_\_\_\_\_\_\_\_\_**  ❑ **Get the Folic Acid You Need**  ❑**Folic Acid: Every Woman, Every Day**\_\_\_\_\_\_\_\_\_\_\_\_  ❑ **Vitamin B12 is Important**  ❑ Anemia, iron prescribed  ❑ Referred to RD (date):  ❑ Client will:  ❑ Referred to RD (date):  ❑ Client will:  ❑ See Question 6 for gestational diabetes interventions.  ❑ Referred to RD (date):  ❑ Client will: |  |
| **Clinical** | | |
| Blood Pressure /  I  Blood Pressure /  2  3  Blood Pressure / | ❑ Provider notified if BP > 120/80  ❑ Provider notified if BP > 120/80  ❑ Provider notified if BP > 120/80 |  |
| 1. Do you have any of the following possibly nutrition- related discomforts?   ❑ nausea ❑ vomiting ❑ leg cramps ❑ gas  I  ❑ heartburn ❑ constipation ❑ hemorrhoids  ❑ swelling of feet or hands ❑ dizziness ❑ diarrhea  ❑ other:  Do any of these discomforts keep you from eating as you  normally would? ❑ No ❑ Yes. Explain:  2  Are there any changes to nutrition- related discomforts?  ❑ No ❑Yes. Explain:  3  Are there any changes to nutrition- related discomforts?  ❑ No ❑Yes. Explain: | ❑ Discussed symptoms with provider Date\_\_\_\_\_\_\_    ❑ Client agrees to follow STT N handout(s) (indicate date):  ❑ **Nausea: Tips that Help** *\_\_\_\_\_\_\_*  ❑ **Nausea: What To Do When You Vomit***\_\_\_\_*  ❑ **Nausea: Choose these Foods** *\_\_\_\_\_* ❑ **Heartburn: What You Can Do** \_\_\_\_\_  ❑ **Heartburn: Should You Use** \_\_\_\_\_  ❑ **Constipation: What You Can Do**\_\_\_\_\_\_  ❑ **Constipation: Products You Can Use and Cannot Use**  ❑ **Do You Have Trouble with Milk Foods?** \_\_\_\_\_\_\_\_\_\_  ❑ Client reviewed WIC handout: Feeling Comfortable While Pregnant [www.cdph.ca.gov/programs/wicworks/Pages/WICEducationMaterialsWomen.aspx](http://www.cdph.ca.gov/programs/wicworks/Pages/WICEducationMaterialsWomen.aspx)  ❑ Referred to RD (date):  ❑ Discussed symptoms with provider  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  ❑ Discussed symptoms with provider  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will: |  |
| 1. Do you have any of these nutrition-related health issues?   ❑ Under 19 years of age  I  ❑ This pregnancy began less than 24 months since a prior birth  ❑ Currently breastfeeding another child  ❑ Gastric Surgery  ❑ Diabetes ❑ Type 1 ❑ Type 2 ❑ Gestational  ❑ Ever had a baby who weighed less than 5 1/2 pounds  ❑ Ever had a baby who weighed more than 9 pounds  ❑ Ever been told any of your unborn babies were not growing well  ❑ Ever had an eating disorder, such as anorexia, bulimia, disordered eating  ❑ Other current or previous nutrition related health issues. Explain:  Are there any new nutrition-related health issues?  2  ❑ No ❑ Yes. Explain:  3  Are there any new nutrition-related health issues?  ❑ No ❑ Yes. Explain: | ❑ Discussed risks with provider Date:  🞏 Client agrees to follow STT N handout(s) (indicate date):  ❑ **MyPlate for Gestational Diabetes**  ❑ **If You Have Diabetes While You Are Pregnant: Questions You May Have**  ❑ **If You Have Diabetes While You Are Pregnant: Relax and Lower Your Stress**  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  ❑ Discussed risks with provider  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:    ❑ Discussed risks with provider  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will: |  |
| **Dietary** | | |
| 1. Are you currently taking any of the following?   I  Which one? How much /often?  ❑ Iron  ❑ Folic Acid  ❑ Prenatal vitamins/minerals  ❑ Other vitamins or mineral  ❑ Home remedies or herbs/teas  ❑ Liquid or powdered supplements  ❑ Laxatives  ❑ Prescription medicines  ❑ Antacids  ❑ Over-the-counter medicines  2  Are there any changes to supplements/medications noted above?  ❑ No ❑ Yes. Explain:  3  Are there any changes to supplements/medications noted above?  ❑ No ❑ Yes. Explain: | ❑ Discussed findings with provider, date:\_\_\_\_\_\_\_\_\_\_  Client agrees to follow STT N handout(s) (indicate date):  ❑ **Take Prenatal Vitamins and Minerals**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ **Get the Folic Acid You Need**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ **Get The Iron You Need**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ **If You Need Iron Pills**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑**Iron Tips\_\_\_\_\_\_\_**❑**Iron Tips: Take Two\_\_\_\_\_\_\_**  ❑**My Action Plan for Iron\_\_\_\_\_\_\_\_\_**  ❑ **Get the Folic Acid You Need**  ❑ **Vitamin B12 is Important** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ **Foods Rich in Calcium** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ **You May Need Extra Calcium**  ❑ **Constipation: What You Can Do**  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will take prenatal vitamins  ❑ Client will:  ❑ Discussed all new findings with provider Date:  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will take prenatal vitamins  ❑ Client will:  ❑ Update: |  |
| Have you had any changes in your appetite or eating habits since becoming pregnant?  I  ❑ No ❑ Yes. Explain:    2  Have you had any changes in your appetite or eating habits?  ❑ No ❑ Yes. Explain:  Have you had any changes in your appetite or eating habits?  3  ❑ No ❑ Yes. Explain: | ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will: |  |
| Do you limit or avoid any food or food groups (such as meat or dairy)?  I  ❑ No ❑ Yes. Explain:  Why do you avoid these foods?  ❑ Do not like ❑ Allergy ❑ Physician advice  ❑ Intolerance ❑ Personal Choice  ❑ Other:  Are there any changes to food groups avoided?  2  ❑ No ❑ Yes. Explain:  3  Are there any changes to food groups avoided?  ❑ No ❑ Yes. Explain: | Client agrees to follow STT N handout(s) (indicate date):  ❑ **Do You Have Trouble with Milk Foods** ❑ **Foods Rich in Calcium**  ❑ **You May Need Extra Calcium**  ❑ **Vitamin B12 is Important**  ❑ **Get the Folic Acid You Need**  ❑ **Get The Iron You Need**  ❑ **If You Need Iron Pills**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑**Iron Tips\_\_\_\_\_\_\_**❑**Iron Tips: Take Two\_\_\_\_\_\_\_**  ❑**My Action Plan for Iron\_\_\_\_\_\_\_\_\_**  ❑ **When You Are a Vegetarian: What Do You Need To Know**  ❑ **Choose Healthy Foods**  ❑**MyPlate for Moms/My Nutrition Plan for****Moms**  ❑ **MyPlate for Gestational Diabetes**  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:    ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will: |  |
| 1. Have you fasted during this pregnancy or do you plan to fast?   ❑ No ❑ Yes. Explain how long and how often:  I  2  ❑ No ❑ Yes. Explain how long and how often:  3  ❑ No ❑ Yes. Explain how long and how often: | ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  Update:  Update: |  |
| 1. Do you ever eat any of the following:   ❑ Raw or undercooked eggs, meat, shellfish, fish, including sushi  I  ❑ Alfalfa/mung bean sprouts  ❑ Deli meat or hot dogs without heating or steaming  ❑ Unpasteurized milk, cheese or juice, including soft cheeses such as feta, blue cheese, queso de crema, asadero, queso fresco, panela, or homemade  ❑ Shark, swordfish, king mackerel, or tilefish  ❑ Albacore tuna >6 ounces/week 🞏 Fish more than 2x/week  🞏 Locally caught fish more than 1x/week  Are there any changes to food choices noted above?  2  ❑ No ❑ Yes. Explain:  3  Are there any changes to food choices noted above?  ❑ No ❑ Yes. Explain: | Client agrees to follow STT N handout(s) (indicate date):  ❑**Don’t Get Sick From the Foods you Eat\_\_\_\_\_\_\_\_**  ❑**Lower Your Chances of Eating Food with Unsafe Chemicals in Them**  ❑ **Checklist for Food Safety\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ❑ **Tips for Cooking and Storing Food\_\_\_\_\_\_\_\_\_\_**  ❑ **Tips for Keeping Foods Safe**  ❑ **Eat Fish Safely**\_\_\_\_\_\_\_\_\_\_\_  ❑ Referred to RD (date):  ❑ Referred to/date:  ❑ Client will:  Update:  Update: |  |
| 1. Do you eat or have you craved any of the following?   ❑ Clay or dirt ❑ Laundry starch ❑ Cornstarch  I  ❑ Ice or freezer frost ❑ Plaster or paint chips  ❑ Other non-food item:  Are there any changes to non-food cravings noted above?  2  ❑ No ❑ Yes. Explain:  3  Are there any changes to non-food cravings noted above?  ❑ No ❑ Yes. Explain: | ❑ Client will:  ❑ Referred to RD (date):  ❑ Referred to/date:  Update:  Update: |  |
| 1. Do you have the following?   ❑ Oven ❑ Electricity ❑ Microwave  I  ❑ Stove ❑ Refrigerator ❑Clean running water  ❑ Missing any of the above  Are there any changes to the responses noted above?  2  ❑ No ❑ Yes. Explain:    3  Are there any changes to the responses noted above?  ❑ No ❑ Yes. Explain: | Client agrees to follow STT N handout(s) (indicate date):  ❑**Tips for Cooking and Storing Food**  ❑**When You Cannot Refrigerate, Choose These Foods**  ❑**Tips for Keeping Food Safe**  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  Update:  Update: |  |
| 1. In the past month, were you worried that your food would run out before you or your family had money to buy more?   I  ❑ No ❑ Yes. Explain:  In the past month, were there times when the food that you or your family bought just did not last and you did not have money to get more? ❑ No ❑ Yes. Explain:  Do you use any of the following food resources?   * WIC: ❑ No ❑Yes WIC Site: * CalFresh (food stamps)? ❑ No ❑ Yes * Any free food, such as from food banks, pantries or soup kitchen? ❑ No ❑Yes     Are there any changes to the food security responses noted above? ❑ No ❑ Yes. Explain:  2  3  Are there any changes to the food security responses noted above? ❑ No ❑ Yes. Explain: | Client agrees to follow STT N handout(s) (indicate date):  ❑ **Tips For Healthy Food Shopping\_\_\_\_\_\_\_\_**  ❑ **You can Buy Healthy Food on a Budget\_\_\_\_\_\_\_\_\_**  ❑ **You Can Stretch Your Dollars: Choose These Easy Meals and Snacks**  ❑ Referred client to WIC  ❑ Referred client to CalFresh (Food Stamps)  ❑ Referred client to local emergency food resources  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  Update:  Update: |  |
| 1. What kinds of physical activity do you do?   I  How often? How long?  On an average day, are you physically active at least 30 minutes each day? ❑Yes ❑ No  On average day, do you spend over 2 hours watching  a screen (TV, computer)? ❑ No ❑ Yes  Has a doctor told you to limit your activity? ❑ No ❑ Yes  Are there any changes in your activity described above?  2  ❑ No ❑Yes. Explain:  Are there any changes in your activity described above?  3  ❑ No ❑ Yes. Explain: | 🞏 Review activity level with provider.  🞏 Client agrees to follow STT HE handout(s) (indicate date):  ❑**Stay Active When Pregnant**  ❑**Keep Safe When You Exercise**  ❑ **Exercises to Do When You are Pregnant**  ❑ Client identified ways to be more active each day  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:  Update:  Update: |  |
| 1. Complete one of these Nutrition Assessments:   ❑ 24-hour Perinatal Dietary Recall  ❑ Perinatal Food Group Recall  ❑ Approved Food Frequency Questionnaire    Complete Nutrition Assessment  2  ❑ 24-hour Perinatal Dietary Recall or  ❑ Perinatal Food Group Recall  ❑ Approved Food Frequency  Complete Nutrition Assessment  3  ❑ 24-hour Perinatal Dietary Recall or  ❑ Perinatal Food Group Recall  ❑ Approved Food Frequency | Client agrees to follow STT N handout(s) (indicate date):  ❑**MyPlate for Moms**  ❑ **MyPlate for Gestational Diabetes**  ❑ Referred to RD (date):  ❑ Referred to (profession and date):  ❑ Client will:    Update:  Update: |  |
| 1. What have you heard about breastfeeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   I  What do you think about breastfeeding your new baby?  ❑ Not interested ❑ Thinking about it ❑ Wants to  ❑ Definitely will ❑ Other  Do you know of the risks of not breastfeeding? ❑ No ❑Yes.  Is there anything that would prevent you from breastfeeding? ❑ No ❑Yes. Explain:  Have you ever breastfed or pumped breast milk for your baby?  ❑ No: Why not?  ❑ Yes. How long?  What was your previous breastfeeding goal?  \_\_\_\_\_\_\_\_\_\_\_  What is your current breastfeeding plan?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    If you are going to breastfeed, who can you go to for breastfeeding help? ­­­­­­­­-\_\_\_\_\_\_\_\_  2  What do you think about breastfeeding your new baby?  ❑ Not interested ❑ Thinking about it ❑ Wants to  ❑ Definitely will ❑ Other:  What are your new questions about feeding your baby?    How do you plan to feed your baby in the first month of life? Mark all that apply:  3  ❑ Human (breast) milk ❑ Formula  ❑ Other:  What are your new questions about feeding your baby? | Client agrees to follow STT N handout(s) (indicate date):  ❑ **Nutrition and Breastfeeding – Common Questions and Answers**  ❑ **How Does Formula Compare to Breastmilk\_\_\_\_\_\_\_\_\_**  ** A Guide to Breastfeeding**  ❑ **My Action Plan for Breastfeeding**  ❑ **My Birth Plan**  ❑ **Breastfeeding Checklist for My Baby and Me**  ❑ **My Breastfeeding Resources**  ❑ **Breastfeeding and Returning to Work or School\_\_\_\_**  ❑ Client received local breastfeeding resources  ❑ Referred to RD (date):  ❑ Referred to lactation consultant:  ❑ Client will:  Update:  Update: |  |
| 1. Do you have any other nutrition questions or concerns? ❑ No ❑ Yes, describe:   I  2  ❑ No ❑ Yes, describe:    3  ❑ No ❑ Yes, describe: | Intervention:  Client goal/plan:  Intervention:  Client goal/plan:  Intervention:  Client goal/plan |  |
| 1. Discussed the nutrition assessment with client and client identified the following strengths:   I  2  3 | | |
| **Nutrition:**  I  Minutes spent Completed by:  Signature Title Date  Signature of medical provider *if assessor is CPHW*:  Signature Title Date  2  Minutes spent Completed by:  Signature Title Date  3  Minutes spent Completed by  Signature Title Date | | |