|  |  |
| --- | --- |
| **CPSP Integrated Initial and & Trimester Assessments and Individualized Care Plan**32I **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 protocolMinutes: 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:

I1. 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 babyI❑ other: | ❑ Referred to/for:❑ Client goal/plan: |  |
| Have you had issues with previous pregnancies? ❑ N/AI❑ 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: IRelationship 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:I1. 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:

I2❑ 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 youused to enjoy? ❑ No ❑ Yes, describe:Ask the above questions, describe response:32Ask 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:

I1. 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 alcoholAre 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: |  |
| 2Are 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:  |  |
| 3Are 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 Number2❑ No ❑ Yes, about hours per day Number3❑ 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? ❑ No2❑ Yes, using: a day/wk./month amount drug  | Update:  |  |
| Are you using drugs now? ❑No❑ Yes, now using: a day/wk./month3 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:23❑ Concerns, describe: | ❑ Client Goal/plan: ❑ Referred to/for: Update: Update:  |  |
| 1. Where do you live? ❑ Apartment/house ❑ other: ❑ Concerns, describe:

I2❑ Concerns/changes, describe:3❑ Concerns/changes, describe: | ❑ Client Goal/plan: ❑ Referred to/for:Update: Update:  |  |
| 1. Any other questions or concerns?

❑ None❑ Yes, describe:I2❑ 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:

I23 |
| **Psychosocial**IMinutes spent Completed by: Signature Title DateSignature of medical provider *if assessor is CPHW*: Signature Title Date2Minutes spent Completed by: Signature Title Date3Minutes 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/groupsI❑ Individual teaching ❑ Videos❑ Other: How well do you write/read? ❑ good/fair ❑ poor/non-reader1. 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/GEDI | ❑ Referred to:  |  |
| 1. How long have you lived in this area? ❑ More than a year

❑ Less than one yearDo 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:

IWhat 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?

IDate: ❑ 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:2I❑ 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 ❑ NoDo you always use a seat belt? 2❑ Yes ❑ No Do you always use a seat belt? ❑ Yes ❑ No3 | ❑ 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:

I2Discussed 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?

3labor 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 ❑ No1. 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

3Name of provider  | ❑ Referred to pediatric provider: ❑ Referred to CHDP provider:  |  |
| 1. Do you plan to have more children? ❑ Yes ❑ No

How many? \_\_\_\_\_3How 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:

I2❑ 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:

I23 |  |
| **Health Education:**IMinutes spent Completed by: Signature Title DateSignature of medical provider *if assessor is CPHW*: Signature Title Date2Minutes spent Completed by: Signature Title Date3Minutes 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\_\_\_\_\_\_\_IBMI 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 IHow 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 ❑ InadequateHow do you feel about the weight you have gained so far with this pregnancy?Current weight gain: 3❑ Appropriate ❑ Excessive ❑ InadequateHow do you feel about the weight you have gained so far with this pregnancy?  | ❑Discussed plotting and reviewing weight gain at every visitClient 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. IHGB HCT Fasting Blood Glucose\_\_\_\_\_\_\_\_\_Date of consultation with provider\_\_\_\_\_\_\_\_\_\_\_Abnormal lab values: ❑ No ❑ Yes, Explain:2Consult 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:3Consult 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 / 23 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 ❑ gasI❑ heartburn ❑ constipation ❑ hemorrhoids ❑ swelling of feet or hands ❑ dizziness ❑ diarrhea ❑ other: Do any of these discomforts keep you from eating as younormally would? ❑ No ❑ Yes. Explain:2Are there any changes to nutrition- related discomforts?❑ No ❑Yes. Explain:3Are 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:3Are 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 2Are there any changes to supplements/medications noted above?❑ No ❑ Yes. Explain:3Are 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: 2Have 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:3Are 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:I2❑ 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/weekAre there any changes to food choices noted above?2❑ No ❑ Yes. Explain:3Are 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 ❑ CornstarchI❑ 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:3Are 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: 3Are 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:23Are 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?

IHow often? How long? On an average day, are you physically active at least 30 minutes each day? ❑Yes ❑ NoOn average day, do you spend over 2 hours watching a screen (TV, computer)? ❑ No ❑ YesHas a doctor told you to limit your activity? ❑ No ❑ YesAre 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 QuestionnaireComplete Nutrition Assessment2❑ 24-hour Perinatal Dietary Recall or❑ Perinatal Food Group Recall❑ Approved Food FrequencyComplete Nutrition Assessment3❑ 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IWhat 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? ­­­­­­­­-\_\_\_\_\_\_\_\_2What 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:

I2❑ 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:

I23 |
| **Nutrition:** IMinutes spent Completed by: Signature Title DateSignature of medical provider *if assessor is CPHW*: Signature Title Date2Minutes spent Completed by: Signature Title Date3Minutes spent Completed by Signature Title Date |