# CCNC Pregnancy Home Risk Screening Form

**Practice Name:** _____

First name: _____ MI___ Last name:_____ Medicaid ID#:_____ Today's date: __/__/____

EDC: __/__/____ By what criteria: ❑ LMP ❑ 1st trimester U/S ❑ 2nd trimester U/S ❑ Other:_____

Height: _____ Pre-pregnancy weight: _____ Gravidity: _____ Parity: ___ ___ ___ ___

Insurance type: ❑ Medicaid ❑ None ❑ Other: _____ Date of birth: __/__/____

## CURRENT PREGNANCY

- ❑ ***Multifetal gestation**
- ❑ ***Fetal complications**:
  - ❑ Fetal anomaly
  - ❑ Fetal chromosomal abnormality
  - ❑ Intrauterine growth restriction (IUGR)
  - ❑ Oligohydramnios
  - ❑ Polyhydramnios
  - ❑ Other: _____
- ❑ ***Chronic condition which may complicate pregnancy**:
  - ❑ Diabetes
  - ❑ Hypertension
  - ❑ Asthma
  - ❑ Mental illness
  - ❑ HIV
  - ❑ Seizure disorder
  - ❑ Renal disease
  - ❑ Systemic lupus erythematosus
  - ❑ Other(s): _____
- ❑ ***Current use of drugs or alcohol/recent drug use or heavy alcohol use** (month prior to learning of pregnancy)
- ❑ ***Late entry into prenatal care (>14 weeks)**
- ❑ ***Hospital utilization in the antepartum period**
- ❑ ***Missed 2+ prenatal appointments**
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Vaginal bleeding in 2nd trimester
- ❑ Hypertensive disorders of pregnancy
  - ❑ Eclampsia
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
  - ❑ HELLP syndrome
- ❑ Short interpregnancy interval (<12 months between last live birth and current pregnancy)
- ❑ Current sexually transmitted infection
- ❑ Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
- ❑ Communication barriers:
  - ❑ Literacy
  - ❑ Disability

  Explain: _____
  - ❑ Non-English speaking

  Primary language: _____

Items marked with a * will trigger follow-up by a pregnancy care manager.

Practice phone no:_____

Next prenatal appt: __/__/_____

❑ No changes since last screen

## OBSTETRIC HISTORY

- ❑ ***Preterm birth** (<37 completed weeks)

Gestational age(s) of previous preterm birth(s):

_____weeks, _____weeks, _____weeks

- ❑ At least one spontaneous preterm labor and/or rupture of the membranes[1]

[1] *If this is a singleton gestation, this patient is eligible for 17P treatment.*

- ❑ ***Low birth weight (<2500g)**
- ❑ ***Very low birth weight (<1500g)**
- ❑ Fetal death >20 weeks
- ❑ Neonatal death (within first 28 days of life)
- ❑ Second trimester pregnancy loss
- ❑ Three or more first trimester pregnancy losses
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Postpartum depression
- ❑ Hypertensive disorders of pregnancy
  - ❑ Eclampsia
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
  - ❑ HELLP syndrome

- ❑ ***Provider requests pregnancy care management**

Reason(s):_____

_____

_____

Provider comments/notes: _____

_____

_____

_____

_____

_____

Name of person completing form: _____ Signature: _____

# CCNC Pregnancy Home Risk Screening Form

**Complete this side of the form and give it to the nurse or doctor. Please answer as honestly as possible so we can provide the best care for you and your baby. The care team will keep this information private.**

Name: _____ Date of birth: _____ Today's date: _____

Physical Address: _____ City: _____ ZIP: _____

Mailing Address (if different): _____ City: _____ ZIP: _____

County: _____ Home phone number: _____ Work phone number: _____

Cell phone number: _____ Social security number: _____

Race: ❑American-Indian or Alaska Native ❑Asian ❑Black/African-American
❑Pacific Islander/Native Hawaiian ❑White ❑Other (specify):_____

Ethnicity: ❑Not Hispanic ❑Cuban ❑Mexican American ❑Puerto Rican ❑Other Hispanic

1. Thinking back to <u>just before you got pregnant</u>, how did you feel about becoming pregnant?
   - ❑ I wanted to be pregnant sooner.
   - ❑ I wanted to be pregnant now.
   - ❑ I wanted to be pregnant later.
   - ❑ I did not want to be pregnant then or any time in the future.
   - ❑ I don't know.
2. *Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ❑ Yes ❑ No
3. *Are you in a relationship with a person who threatens or physically hurts you? ❑ Yes ❑ No
4. *Has anyone forced you to have sexual activities that made you feel uncomfortable? ❑ Yes ❑ No
5. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food? ❑ Yes ❑ No
6. *Is your living situation unsafe or unstable? ❑ Yes ❑ No
7. *Which statement best describes your smoking status? Check one answer.
   - ❑ A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
   - ❑ B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
   - ❑ C. *I stopped smoking AFTER I found out I was pregnant and am not smoking now.
   - ❑ D. *I smoke now but have cut down some since I found out I was pregnant.
   - ❑ E. *I smoke about the same amount now as I did before I found out I was pregnant.
8. Did any of your parents have a problem with alcohol or other drug use? ❑ Yes ❑ No
9. Do any of your friends have a problem with alcohol or other drug use? ❑ Yes ❑ No
10. Does your partner have a problem with alcohol or other drug use? ❑ Yes ❑ No
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? ❑ Yes ❑ No
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs? ❑Not at all ❑Rarely ❑Sometimes ❑Frequently
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs? ❑Not at all ❑Rarely ❑Sometimes ❑Frequently

*(For Pregnancy Care Management use only)* Date risk screening form was received: ___/___/_____