# CCNC Pregnancy Home Risk Screening Form

## Practice information

**1**

Practice name _____ Practice phone _____

## Patient information

**2**

Full name _____

Medicaid ID _____ Today's Date (mm/dd/yyyy) _____

EDC (mm/dd/yyyy) _____ 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 (mm/dd/yyyy) _____

Next prenatal appt (mm/dd/yyyy) _____ ◯ No changes since last screen

## Current pregnancy

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

**3**

☐ ***Multifetal gestation**

☐ ***Fetal complications** (check all that apply)

- ☐ Fetal anomaly
- ☐ Fetal chromosomal abnormality
- ☐ Intrauterine growth restriction (IUGR)
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Other _____

☐ ***Chronic condition which may complicate pregnancy** (check all that apply)

- ☐ Asthma
- ☐ Diabetes
- ☐ HIV
- ☐ Hypertension
- ☐ Mental illness
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Systemic lupus erythematosus
- ☐ Other _____

☐ ***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 (choose one)

- ◯ Eclampsia
- ◯ Gestational hypertension
- ◯ HELLP syndrome
- ◯ Preeclampsia

☐ 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 (check all that apply)

- ☐ Disability ☐ Literacy Explain: _____
- ☐ Non-English speaking Primary language: _____

## Obstetric history

**4**

- ☐ ***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*
  **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 (choose one)
  - ◯ Eclampsia
  - ◯ Gestational hypertension
  - ◯ HELLP syndrome
  - ◯ Preeclampsia

## Pregnancy care management

**5**

- ☐ ***Provider requests pregnancy care management**

Reason(s) _____

_____

_____

_____

Comments/notes _____

_____

_____

_____

## Provider signature

**6**

Name of person completing form _____

Signature of provider

| x | | |
|---|---|---|

Today's date (mm/dd/yyyy)

Alliance Health

Complete this 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.

**TO BE COMPLETED BY PATIENT**

## Obstetric history

**7**

Full name _____

Date of birth (mm/dd/yyyy) _____ Today's date (mm/dd/yyyy) _____

Physical address

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ County _____ State _____ Postal code _____

Mailing address (if different)

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ County _____ State _____ Postal code _____

Home phone _____ Work phone _____ Cell phone _____

SSN ☐☐☐-☐☐-☐☐☐☐

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

Ethnicity
- ◯ Cuban
- ◯ Mexican American
- ◯ Puerto Rican
- ◯ Other Hispanic
- ◯ Not Hispanic

## Questionnaire

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

**8**

**1.** Thinking back to just before you got pregnant, 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? (choose one)
- ◯ **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

## Questionnaire

Continuation

**8**

**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**

**9** Date risk screening form was received (mm/dd/yyyy) _____