CPSP Integrated Initial [I] and △2 & △3 Trimester Assessments and Individualized Care Plan

Supervising physician signature:_____
Date of signature:_____

[I] Complete all these items at the initial assessment regardless of which trimester she is in.

Patient Identifier

❑ CPSP **Client Orientation** per protocol. Minutes spent: _____

Completed by: _____ _____ _____
Signature Title Date

1. Pregnancy Information [I]

DOB: _____ Age: _____ Grav: _____ Para: _____ TAB: _____ SAB: _____

EDC: _____ Weeks Gestation: _____ **Review medical problem list before conducting assessments.**

Psychosocial

Low Risk	[I] Psychosocial Risks/Concerns	Psychosocial Individualized Care Plan
Yes	2. Planned pregnancy? ❑ No, describe:	❑ Provided emotional support
Yes	3. Wanted pregnancy? ❑ No, describe:	
No	4. Considering abortion/adoption? ❑ Yes, describe:	❑ Consult with ob provider ❑ Referred to:
Yes	5. FOB/partner accepts pregnancy? ❑ No, describe:	❑ Provided emotional support ❑ Referred to:
	6. Goals for this pregnancy: ❑ healthy baby ❑ other:	❑ Discussed:
No N/A	7. Problems with previous pregnancies? ❑ Yes, describe:	❑ Consult with ob provider ❑ Provided emotional support
No N/A	8. Previous pregnancy loss/infant death? ❑ Yes, describe:	❑ Provided emotional support ❑ Referred to:
	9. Members of household (not including patient) Number of adults: _____ Relationship to patient: Number of children: _____ Relationship to patient:	
Yes N/A	10. Patient's children all live with her? ❑ No, describe:	❑ Provided emotional support ❑ If history of abuse/neglect, referred to:
No	11. Ever seen a counselor for personal or family problems? ❑ Yes, describe:	❑ Provided emotional support ❑ Referred to:
No	12. Ever been emotionally, physically, or sexually abused by a partner or someone close to you? ❑ Yes, describe:	❑ Discussed cycle of violence ❑ Assessed danger to patient ❑ Made safety plan ❑ Reviewed legal options ❑ Referred to:
No	13. Within the last year ever been hit, slapped, kicked, pushed, shoved, forced to have sex, forced to get pregnant, or otherwise physically hurt by partner or ex-partner? ❑ Yes, describe:	If current injuries, ❑ Referred to ob provider ❑ Reported to law enforcement ❑ In contact with law enforcement/agency already:

This form is approved and supported by funds received from the California Department of Public Health, Maternal Child and Adolescent Health Division. 2011

Low Risk	**Psychosocial Risks/ Concerns** I 2 3	**Psychosocial Individualized Care Plan**
No	14. Afraid of partner or ex-partner? I ❑ Yes, describe:	❑ Discussed cycle of violence ❑ Assessed danger to patient ❑ Made safety plan ❑ Reviewed legal options ❑ Referred to: If current injuries, ❑ Referred to ob provider ❑ Reported to law enforcement ❑ In contact with law enforcement/agency already:
No	2 ❑ Yes, describe:	❑ Discussed cycle of violence ❑ Assessed danger to patient ❑ Made safety plan ❑ Reviewed legal options ❑ Referred to: If current injuries, ❑ Referred to ob provider ❑ Reported to law enforcement ❑ In contact with law enforcement/agency already:
No	3 ❑ Yes, describe:	❑ Discussed cycle of violence ❑ Assessed danger to patient ❑ Made safety plan ❑ Reviewed legal options ❑ Referred to: If current injuries, ❑ Referred to ob provider ❑ Reported to law enforcement ❑ In contact with law enforcement/agency already:
No	15. Currently having any personal or family problems? I ❑ Yes, describe:	❑ Provided emotional support ❑ Referred to:
No	2 ❑ Yes, describe:	❑ Provided emotional support ❑ Referred to:
No	3 ❑ Yes, describe:	❑ Provided emotional support ❑ Referred to:
Yes	16. Has someone to turn to for emotional support? I ❑ FOB/partner ❑ family member: ❑ friend: ❑ other: ❑ No one, describe:	❑ Provided emotional support ❑ Referred to:
Yes	2 ❑ No one, describe:	❑ Provided emotional support ❑ Referred to:
Yes	3 ❑ No one, describe:	❑ Provided emotional support ❑ Referred to:

No	17. Currently receiving services from a local agency such as case management, counseling etc.? I ❑ Yes, describe:	❑ Obtained patient's written permission to share information with: Agency: Contact person: Phone: Fax:
No	2 ❑ Yes, describe:	❑ Obtained patient's written permission to share information with: Agency: Contact person: Phone: Fax:
No	3 ❑ Yes, describe:	❑ Obtained patient's written permission to share information with: Agency: Contact person: Phone: Fax:
No	18. Often feels down, sad or hopeless? ❑ Yes, describe: I	❑ Provided emotional support ❑ Assess for signs of emotional concerns at future appointments
No	Often feels irritable, restless or anxious? ❑ Yes, describe:	❑ Consulted with ob provider ❑ Referred to:
No	Lost interest or pleasure in doing things that she used to enjoy? ❑ Yes, describe:	❑ Provided emotional support ❑ Consulted with ob provider
No	2 ❑ Yes, describe:	❑ Referred to:
No	3 ❑ Yes, describe:	❑ Provided emotional support ❑ Discussed postpartum emotional changes (baby blues) ❑ Consulted with ob provider ❑ Referred to:
No	19. Did your parents have problems with alcohol or drugs? I ❑ Yes, describe:	❑ Provided emotional support ❑ Referred to:
No	20. Does your partner have problems with alcohol or drugs? I ❑ N/A ❑ Yes, describe:	❑ Provided emotional support ❑ Referred to:
None	21. Before you knew you were pregnant, how much beer/wine/liquor did you drink? I ❑ was drinking ____ _____ a day/wk/month amount type of alcohol	❑ Reinforced patient's decision not to drink alcohol ❑ Advised of risks ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10
None	❑ now drinking ____ _____ a day/wk/month amount type of alcohol	❑ Support person:
No	❑ drinks a lot at one time (4 or more drinks in about 2 hours):_____ a day/wk/month times	❑ Consult with ob provider ❑ Referred to:

None No	2 ❑ drinking ____ _____ a day/wk/month amount type of alcohol ❑ drinks a lot at one time (4 or more drinks in about 2 hours):_____ a day/wk/month times	❑ Reinforced patient's decision not to drink alcohol ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Consult with ob provider ❑ Referred to:
None No	3 ❑ drinking ____ _____ a day/wk/month amount type of alcohol ❑ drinks a lot at one time (4 or more drinks in about 2 hours):_____ a day/wk/month times	❑ Reinforced patient's decision not to drink alcohol ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Consult with ob provider ❑ Referred to:
None	22. Before you knew you were pregnant, how much tobacco did you smoke? I ❑ was smoking _____ cigarettes a day Now ❑ stopped smoking and is not smoking now ❑ cut down on the number of cigarettes to ____ a day ❑ smoking about the same number of cigarettes a day	❑ Reinforced patient's decision not to smoke ❑ Advised of risks ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Reviewed: ❑ Faxed referral to CA Smokers' Helpline ❑ Consult with ob provider ❑ Referred to:
None	2 Smoking: ❑ cut down to ____ cigarettes a day ❑ smoking about the same number of cigarettes a day	❑ Reinforced patient's decision not to smoke ❑ Advised of risks ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Reviewed: ❑ Faxed referral to CA Smokers' Helpline ❑ Consult with ob provider ❑ Referred to:

None	3 Smoking: ❑ cut down to ____ cigarettes a day ❑ smoking about the same number of cigarettes a day	❑ Reinforced patient's decision not to smoke ❑ Advised of risks ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Reviewed: ❑ Faxed referral to CA Smokers' Helpline ❑ Consult with ob provider ❑ Referred to:
	23. Exposed to 2nd hand smoke at home/elsewhere?	
No	I ❑ Yes, about _____ hours per day number	❑ Advised to avoid second-hand smoke ❑ Patient will talk to others about keeping home and car smoke-free
No	2 ❑ Yes, about _____ hours per day number	❑ Advised to avoid second-hand smoke ❑ Patient will talk to others about keeping home and car smoke-free
No	3 ❑ Yes, about _____ hours per day number	❑ Advised to avoid second-hand smoke ❑ Patient will talk to others about keeping home and car smoke-free
	24. 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	❑ Reinforced patient's decision not to use any drugs ❑ Advised of risks ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10
None	❑ now using ____ _____ a day/wk/month amount drug	❑ Support person: ❑ Reviewed: ❑ Consult with ob provider ❑ Referred to: ❑ Obtained patient's written permission to exchange information with: Agency: Contact person: Phone: Fax:
None	2 ❑ now using: ____ _____ a day/wk/month amount drug	❑ Reinforced patient's decision not to use any drugs ❑ Advised of risks ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Reviewed: ❑ Consult with ob provider ❑ Referred to: ❑ Obtained patient's written permission to exchange information with: Agency: Contact person: Phone: Fax:

None	3 ❑ now using: ____ _____ a day/wk/month amount drug	❑ Reinforced patient's decision not to use any drugs ❑ Advised of risks ❑ Agreed to cut down/quit: Confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Reviewed: ❑ Consult with ob provider ❑ Referred to: ❑ Obtained patient's written permission to exchange information with: Agency: Contact person: Phone: Fax:
	25. Source of financial support: I ❑ self, type of work: ❑ FOB/partner, type of work: ❑ family member/ friend: ❑ CalWORKS ❑ SSI ❑ other:	
No	❑ Problems, describe:	❑ Referred to:
No	2 ❑ Problems, describe:	❑ Referred to:
No	3 ❑ Problems, describe:	❑ Referred to:
	26. Type of housing: I ❑ apartment/house ❑ other: _____ ❑ Problems, describe:	❑ Referred to:
No		
No	2 ❑ Problems, describe:	❑ Referred to:
No	3 ❑ Problems, describe:	❑ Referred to:
No	27. Other psychosocial risk or concern: I ❑ Yes, describe:	I
	2 ❑ Yes, describe:	2
	3 ❑ Yes, describe:	3

Psychosocial:

[I] minutes spent _____ Completed by:_____
Signature Title Date

Reviewed by 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

Low Risk/ Strength	[I] Health Education Learning Needs/Risks/Concerns	Health Education Individualized Care Plan and Barriers to Learning
	28. Likes to learn by: ❑ reading/handouts ❑ classes/groups ❑ individual teaching ❑ videos ❑ other:	❑ Will use patient's preferred learning methods, as available
Yes	29. Person to share in your prenatal education: ❑ No, comments:	❑ Encourage her to involve a support person by sharing educational materials after her appointments
Good Good	30. Patient's primary language: _____ writing/reading ❑ fair ❑ poor ❑ non-reader Other language spoken: _____ ❑ none writing/reading ❑ fair ❑ poor ❑ non-reader Prefers materials in: _____ language	❑ Will adapt education methods, such as using pictures or low literacy materials
12th or over	31. Last grade completed:_____	❑ Less than 12th grade, will adapt education methods such as using pictures or low literacy materials
Yes Yes	32. Born in the United States? ❑ If not, country of birth: _____ Length of time living in US: _____months/years 33. Ever used health care services in U.S.? ❑ No, comments:	 ❑ Provided education about health care services
No	34. Any disabilities that affect learning? (such as vision, hearing, learning disabilities) ❑ Yes, describe:	❑ Will adapt health education methods ❑ Consult with ob provider ❑ Referred to:
Yes Yes	35. Previous knowledge/experience with: pregnancy ❑ No prenatal care ❑ No	❑ Reviewed:

	36. Who gives advice about being pregnant? ❑ No one ❑ mother ❑ mother-in-law ❑ grandmother ❑ partner ❑ friend: ❑ other: 37. What are the most important things they have advised?	❑ Consult with ob provider regarding any harmful advice
No	38. Exposed to dangers at work or home such as ❑ chemicals, fumes, pesticides, lead ❑ cats ❑ rodents ❑ douching ❑ hot baths ❑ x-rays ❑ other:	❑ Reviewed *Pregnant? Steps for a Healthy Baby* ❑ Consult with ob provider re: ❑ Gave patient CTIS phone number (800-532-3749) and/or website for additional information www.ctispregnancy.org ❑ Mailed or faxed CTIS patient referral form
Low Risk/ Need	**Health Education Risks/ Concerns** I 2 3	**Health Education Individualized Care Plan**
Yes	39. Interested in learning about prenatal topics such as body changes during pregnancy, baby's growth, etc.? I ❑ No, describe:	❑ Low interest in learning ❑ Consult with ob provider re: ❑ Discussed:
Yes	2 ❑ No, describe:	❑ Low interest in learning ❑ Consult with ob provider re: ❑ Discussed:
Yes	3 ❑ No, describe:	❑ Low interest in learning ❑ Consult with ob provider re: ❑ Discussed:
Yes	40. Dental check-up within past 12 months? I ❑ No:	Reviewed STT HE ❑ *Prevent Gum Problems* ❑ *See a Dentist* ❑ *Keep Teeth Healthy* ❑ Consult with ob provider ❑ Completed Prenatal Dental Referral ❑ Referred to:
No	Teeth, gums or mouth problems? ❑ Yes, describe:	
No	2 Teeth, gums or mouth problems? ❑ Yes, describe:	Reviewed STT HE ❑ *Prevent Gum Problems* ❑ *See a Dentist* ❑ *Keep Teeth Healthy* ❑ Consult with ob provider ❑ Completed Prenatal Dental Referral ❑ Referred to:
No	3 Teeth, gums or mouth problems? ❑ Yes, describe:	Reviewed STT HE ❑ *Prevent Gum Problems* ❑ *See a Dentist* ❑ *Keep Teeth Healthy* ❑ Consult with ob provider ❑ Completed Prenatal Dental Referral ❑ Referred to:
No	41. Transportation to clinic: ❑ bus ❑ car ❑ walk I ❑ other: ❑ Problems, describe:	❑ Suggested solution(s):
No	2 ❑ Problems, describe:	❑ Suggested solution(s):
No	3 ❑ Problems, describe:	❑ Suggested solution(s):

Yes	42. Knows how to use seat belt when pregnant? I ❑ No	❑ Demonstrated safe seat belt use ❑ Reviewed *What's the Right Way to Wear My Seat Belt*
Yes	2 ❑ No	❑ Demonstrated safe seat belt use ❑ Reviewed *What's the Right Way to Wear My Seat Belt*
Yes	3 ❑ No	❑ Demonstrated safe seat belt use ❑ Reviewed *What's the Right Way to Wear My Seat Belt*
No	43. Patient has questions about danger signs, preterm labor and when to call the doctor for prenatal concerns? I ❑ Yes, describe:	Reviewed STT HE ❑ *Danger Signs* ❑ *If Labor Starts Too Early* ❑ Consult with ob provider
No	2 ❑ Yes, describe:	❑ Reviewed STT HE *Kick Counts* if more than 28 weeks ❑ *Danger Signs* ❑ *If Labor Starts Too Early* ❑ Consult with ob provider
No	3 ❑ Yes, describe:	❑ Reviewed STT HE *Kick Counts* if more than 28 weeks ❑ *Danger Signs* ❑ *If Labor Starts Too Early* ❑ Consult with ob provider
Yes	44. Experience with delivery/postpartum self-care? 3 ❑ No	❑ Discussed childbirth preparation ❑ Referred to hospital tour
Yes Yes Yes Yes	45. Has plans for labor and delivery? labor support person ❑ No signs of labor, when to call ❑ No plans for transportation to hospital ❑ No childcare plans for other kids ❑ No	❑ Referred to childbirth preparation class ❑ Discussed options for labor and delivery support ❑ Reviewed signs of labor, when to call ❑ Discussed options for transportation to hospital ❑ Discussed options for childcare plans for other kids
Yes	46. Experience with infant care, safety and illness? 3 ❑ No	Reviewed STT HE ❑ *Babies Sleep Safest* ❑ *Keep Your New Baby Safe* ❑ *When Newborn is Ill* ❑ *Baby Needs Immunization* ❑ Advised correctly-installed car seats are required by law
Yes Yes Yes N/A	47. Preparations for baby ❑ baby supplies/clothing/safe sleeping ❑ child passenger safety seat ❑ if returning to work or school, has child care plans	❑ Advised crib slats no more than 2 3/8 inches apart and other crib safety tips ❑ Advised to call: ❑ Referred to:
Yes	48. Has pediatric provider? ❑ No 3	❑ Referred to pediatric provider:
Yes	49. Plans for future children? 3 Number of children planned: _____ Spacing of children planned: Contraceptive method(s) selected: Does partner support patient's decision for use of birth control? ❑ No, describe:	❑ Has family planning provider ❑ Referred to family planning provider ❑ Advised patient to consult with obstetric provider if planning to get pregnant again less than 18 months after the birth of this child. ❑ Advised patient to consult with obstetric provider if patient's partner does not support her use of birth control.

Yes	50. Has primary care provider for her regular medical check ups? ❑ No △3	❑ Advised patient to call: ❑ Referred to:
Yes	51. Has health insurance for her health care in the future? ❑ No	❑ Referred to clinic eligibility worker ❑ Referred to:
No	52. Any health problems that need follow up postpartum? (diabetes, hypertension, obesity, depression etc.) △3 ❑ Yes, describe:	❑ Encouraged patient to make appointment with primary care provider ❑ Referred to:
No	53. Other health education risk or concern: I ❑ Yes, describe: △2 ❑ Yes, describe: △3 ❑ Yes, describe:	I △2 △3

Health Education:

I minutes spent _____ Completed by:_____
Signature Title Date

Reviewed by 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

54. Weight pre-pregnancy: _____ lbs.
55. Height _____ feet ____ inches
56. Weight gain grid used:
    ❑ Underweight ❑ Normal
    ❑ Overweight ❑ Obese

Low Risk	I **Nutrition Risks/Concerns**	**Nutrition Individualized Care Plan**
No	57. Any foods or food groups avoided (such as meat or dairy)? ❑ Yes, list which foods and note reason:	Reviewed STT N ❑ *Vegetarian Eating* ❑ *Choose Healthy Foods* ❑ *Trouble with Milk Foods* ❑ *Foods Rich in Calcium* ❑ No major impact on food intake ❑ Consult with ob provider re:
No	58. Allergic to foods? ❑ Yes, describe:	❑ Referred to:
No	59. Do you eat raw or undercooked eggs/seafood/meat? ❑ Yes, describe:	❑ Reviewed: *Pregnant? Steps for a Healthy Baby* Advised patient: ❑ not to eat raw or undercooked meat /seafood/ eggs
No	60. Do you eat deli meats or hot dogs? ❑ Yes, describe:	❑ not to eat hot dogs, luncheon meats or deli meats unless reheated to steaming hot
No	61. Do you eat soft cheeses such as feta, blue cheese, queso de crema, asadero, queso fresco or panela? ❑ Yes, describe:	❑ not to eat soft cheeses unless labels show that they are pasteurized ❑ not to eat any shark, swordfish, tilefish or king mackerel
No	62. Do you eat fish? ❑ Yes, describe:	❑ not to eat more than 6 oz. of albacore tuna per week ❑ not to eat more than 12 oz. of other kinds of fish per week
No	63. Do you eat fish caught by friends or family? ❑ Yes, describe:	❑ to check local fish advisories if eating fish caught by friends and family ❑ Consult with ob provider re:
No	64. Food or non-food cravings? (non-foods such as ice, plaster, cornstarch, dirt, clay, laundry starch) ❑ Yes, describe:	❑ No negative impact on food intake ❑ Consult with ob provider
None	65. Currently taking (in addition to prenatal vitamins) (if yes, note type, amount, frequency): ❑ over-the-counter drugs: ❑ prescription medicines: ❑ herbs, vitamins, mineral supplements: ❑ home remedies: ❑ other:	❑ Advised patient to check with ob provider before taking any drugs, medicines, supplements or home remedies ❑ Consult with ob provider re:
Low Risk	**Nutrition Risks/ Concerns** I 2 3	**Nutrition Individualized Care Plan**
	66. **Today's weight** _____ lbs. I Weight gain to date this pregnancy: _____ lbs.	❑ Weight gain plotted on appropriate grid ❑ Reviewed:
	2 **Today's weight** _____ lbs. Weight gain to date this pregnancy: _____ lbs.	❑ Weight gain plotted on appropriate grid ❑ Reviewed:
	3 **Today's weight** _____ lbs. Weight gain to date this pregnancy: _____ lbs.	❑ Weight gain plotted on appropriate grid ❑ Reviewed:

Yes	67. Current weight gain appropriate? [I] ❑ No, excessive weight gain ❑ No, inadequate weight gain	Reviewed STT N ❑ *Tips To Gain Weight* ❑ *Tips to Slow Weight Gain* ❑ Consult with ob provider re: ❑ Referred to:
Yes	2 ❑ No, excessive weight gain ❑ No, inadequate weight gain	Reviewed STT N ❑ *Tips To Gain Weight* ❑ *Tips to Slow Weight Gain* ❑ Consult with ob provider re: ❑ Referred to:
Yes	3 ❑ No, excessive weight gain ❑ No, inadequate weight gain	Reviewed STT N ❑ *Tips To Gain Weight* ❑ *Tips to Slow Weight Gain* ❑ Consult with ob provider re: ❑ Referred to:
Yes	68. [I] Completed the 24-hour recall or food frequency form	❑ Reviewed: ❑ Consult with ob provider re:
Yes	2 Completed the 24-hour recall or food frequency form	❑ Reviewed: ❑ Consult with ob provider re:
Yes	3 Completed the 24-hour recall or food frequency form	❑ Reviewed: ❑ Consult with ob provider re:
	69. Number of times per day usually eats? [I] 1 2 3 4 5 6 7 or more	❑ Advised to eat every 3-4 hours ❑ Discussed reason for infrequent eating ❑ Referred to:
No	Eats less than 3 times/day? ❑ Yes, describe:	
No	2 Eats less than 3 times/day? ❑ Yes, describe:	❑ Advised to eat every 3-4 hours ❑ Discussed reason for infrequent eating ❑ Referred to:
No	3 Eats less than 3 times/day? ❑ Yes, describe:	❑ Advised to eat every 3-4 hours ❑ Discussed reason for infrequent eating ❑ Referred to:
No	70. Current discomforts? [I] ❑ nausea ❑ vomiting ❑ swelling ❑ diarrhea ❑ heartburn ❑ constipation ❑ other:	Reviewed STT N ❑ *Nausea* ❑ *Vomiting* ❑ *Heartburn* ❑ *Antacids* ❑ *Constipation* ❑ *Products for Constipation* ❑ Consult with ob provider re:
No	2 ❑ Yes, describe:	Reviewed STT N ❑ ❑ Consult with ob provider re:
No	3 ❑ Yes, describe:	Reviewed STT N ❑ ❑ Consult with ob provider re:
No	71. Nutrition-related medical conditions? [I] (such as obesity, diabetes, hypertension, anemia) ❑ Yes, describe:	Reviewed STT N ❑ *If You Need Iron Pills* ❑ Consult with ob provider re: ❑ Refer to:
No	2 ❑ Yes, describe:	❑ Consult with ob provider re: ❑ Refer to:
No	3 ❑ Yes, describe:	❑ Consult with ob provider re: ❑ Refer to:

	72. Knowledge or experience with breastfeeding? [I] ❑ observed friends/family ❑ no knowledge or experience Personal experience has been ❑ Mostly positive ❑ Not applicable ❑ Mostly negative	
Yes	73. Planning to breastfeed? [I] ❑ No ❑ Combine with formula ❑ Not sure	❑ Discussed breastfeeding benefits Reviewed STT N ❑ *Here's How to Get Started*
Yes	△2 ❑ No ❑ Combine with formula ❑ Not sure	❑ Discussed breastfeeding benefits Reviewed STT N ❑ *Here's How to Get Started*
Yes	△3 ❑ No ❑ Combine with formula ❑ Not sure	Reviewed STT N ❑*Here's How to Get Started* ❑ *First Time You Breastfeed* ❑ *Making Plenty of Milk* ❑ *How to Know your Baby is Getting Plenty of Milk*
Yes N/A	Does your family support your decision to breastfeed? ❑ No, describe:	❑ *Going Back to Work or School* ❑ *You Can Pump and Store* ❑ Discussed local breastfeeding resources ❑ Discussed family support for breastfeeding
	74. Currently taking prenatal vitamins?	Reviewed STT N ❑ *Prenatal Vitamins*
Yes	[I] ❑ No, describe:	❑ Encouraged patient to take prenatal vitamins
Yes	△2 ❑ No, describe:	❑ Encouraged patient to take prenatal vitamins
Yes	△3 ❑ No, describe:	❑ Encouraged patient to take prenatal vitamins
Yes	75. Already enrolled in WIC? Site: [I] ❑ No, describe:	❑ Referred to WIC site: ❑ Referred to CalFresh (Food Stamps) ❑ Referred to Emergency Food Box
No	76. Ever run out of food? [I] ❑ Yes, describe:	Reviewed STT N ❑ *Shopping Tips* ❑ *Stretch Your Dollars* ❑ *Low-Cost Healthy Foods*
No	△2 ❑ Yes, describe:	❑ Referred to WIC site: ❑ Referred to CalFresh (Food Stamps) ❑ Referred to Emergency Food Box Reviewed STT N ❑ *Shopping Tips* ❑ *Stretch Your Dollars* ❑ *Low-Cost Healthy Foods*
No	△3 ❑ Yes, describe:	❑ Referred to WIC site: ❑ Referred to CalFresh (Food Stamps) ❑ Referred to Emergency Food Box Reviewed STT N ❑ *Shopping Tips* ❑ *Stretch Your Dollars* ❑ *Low-Cost Healthy Foods*
Yes	77. Have access to a kitchen/way to cook and store food? [I] ❑ No, describe:	Reviewed STT N ❑ *Tips for Cooking / Storing* ❑ *When You Cannot Refrigerate* ❑ *Tips for Keeping Food Safe*
Yes	△2 ❑ No, describe:	Reviewed STT N ❑ *Tips for Cooking / Storing* ❑ *When You Cannot Refrigerate* ❑ *Tips for Keeping Food Safe*
Yes	△3 ❑ No, describe:	Reviewed STT N ❑ *Tips for Cooking / Storing* ❑ *When You Cannot Refrigerate* ❑ *Tips for Keeping Food Safe*

Yes	78. Physically active at least 30 minutes each day? I ❑ No, describe:	❑ Discussed ways to be more active each day Reviewed STT HE ❑ *Stay Active When Pregnant* ❑ *Keep Safe When You Exercise*
Yes	△2 ❑ No, describe:	❑ Discussed ways to be more active each day Reviewed STT HE ❑ *Stay Active When Pregnant* ❑ *Keep Safe When You Exercise*
Yes	△3 ❑ No, describe:	❑ Discussed ways to be more active each day Reviewed STT HE ❑ *Stay Active When Pregnant* ❑ *Keep Safe When You Exercise*
	79. ❑ Reviewed urine ketones, glucose, protein, blood glucose screen, HGB or HCT, and BP I	❑ Obstetric provider to review
	△2 ❑ Reviewed urine ketones, glucose, protein, blood glucose screen, HGB or HCT, and BP	❑ Obstetric provider to review
	△3 ❑ Reviewed urine ketones, glucose, protein, blood glucose screen, HGB or HCT, and BP	❑ Obstetric provider to review
No	80. Other nutrition risk/dietary issue I ❑ Yes, describe:	I
	△2 ❑ Yes, describe:	△2
	△3 ❑ Yes, describe:	△3

Nutrition

I minutes spent _____ Completed by:_____
Signature Title Date

Reviewed by 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