



PRENATAL RISK SCREEN

This form must be completed in ink.



Pursuant to § 383.14(1)(a) and 383.011(1)(e), F.S., this form must be completed by the health care provider for every pregnant woman and submitted to the local county health department.

Name: First _____ Last _____ M.I. _____		County: _____		Today's Date (month/day/year): _____	
Street address (apartment complex name/number): _____			City or town: _____		State: _____ Zip code: _____
Mailing address (if different from street address): _____			City or town: _____		State: _____ Zip code: _____
Home phone: _____	Work phone or other: _____	Date of Birth (mo/day/yr): _____	Age: _____	Social security number: _____	Race: black <input type="checkbox"/> white <input type="checkbox"/> other <input type="checkbox"/>
Are you married? yes <input type="checkbox"/> no <input type="checkbox"/>	Have you graduated from high school or received a GED? yes <input type="checkbox"/> no <input type="checkbox"/>		When you were born, did you weigh 5½ pounds or less? yes <input type="checkbox"/> no <input type="checkbox"/> don't know <input type="checkbox"/>		
Weight before pregnancy: lbs. _____	Height: ft. _____ in. _____	Is this your first pregnancy? yes <input type="checkbox"/> no <input type="checkbox"/> If no, give date your last pregnancy ended (include live birth, stillbirth, miscarriage, abortion). Date: (month/year) _____			
Is your prenatal care covered by: Health Insurance/HMO <input type="checkbox"/> _____ Medicaid <input type="checkbox"/> Other Health Insurance (Military, Indian Health, etc.) <input type="checkbox"/> _____ No Coverage <input type="checkbox"/>					

Census Tract (local use)

To be completed by Health Professional

A<18 (1)

A>39 (1)

RB (2)

MN T (1)

PHN T

EN T (1)

W<110 (1)

SECTION 1: COMPLETED BY PATIENT

Yes _____ No _____ (please initial) I am interested in being screened for risks that could affect my pregnancy, my health, or my baby. If yes, complete the following screening questions by **checking** the appropriate boxes.

- | Yes | No | N/A | (please check appropriate box) | |
|--|--------------------------|--------------------------|--|----------|
| 1. <input type="checkbox"/> | <input type="checkbox"/> | | 1. Do you have any problems that prevent you from keeping your health care or social services appointments? | 1Y (1) |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | | 2. Have you moved more than 3 times in the last 12 months? | 2Y T (1) |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | | 3. Do you feel unsafe where you live? | 3Y (1) |
| 4. <input type="checkbox"/> | <input type="checkbox"/> | | 4. Do you or any member of your household go to bed hungry? | 4Y (1) |
| 5. <input type="checkbox"/> | <input type="checkbox"/> | | 5. In the last 2 months, have you used any form of tobacco? | 5Y (1) |
| 6. <input type="checkbox"/> | <input type="checkbox"/> | | 6. In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)? | 6Y T (1) |
| 7. <input type="checkbox"/> | <input type="checkbox"/> | | 7. In the last year, has anyone hit you or tried to hurt you? | 7Y T |
| 8. a <input type="checkbox"/> b <input type="checkbox"/> c <input type="checkbox"/> | | | 8. How do you rate your current stress level? (a) low, (b) medium, (c) high | 8C T |
| 9. a <input type="checkbox"/> b <input type="checkbox"/> c <input type="checkbox"/> d <input type="checkbox"/> | | | 9. If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, (d) no change | 9C T (1) |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | | 10. Have you considered adoption for this pregnancy? | 10Y T |
| 11. <input type="checkbox"/> | <input type="checkbox"/> | | 11. Do you now, or have you ever had, problems with depression? | 11Y T |
| 12. <input type="checkbox"/> | <input type="checkbox"/> | | 12. Do you have a history of receiving mental health counseling? | 12Y T |
| 13. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Is your partner unemployed? | 13Y T |

Yes _____ No _____ (please initial) If I am referred, Healthy Start may contact me. The best time to contact me is: _____

Yes _____ No _____ (please initial) By initialing yes, I am giving my written permission for release of the confidential information on this form and any information provided during my evaluation for service by Healthy Start to Healthy Start care coordination providers, Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: care coordination, payment of claims for services, quality improvement of services, or screening for program eligibility. This includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. This authorization shall remain in effect unless withdrawn in writing.

Signature of patient or guardian _____ Date (mo/day/yr) _____

SECTION 2: BY PROVIDER

- | Yes | No | N/A | |
|------------------------------|--------------------------|--------------------------|---|
| 14. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. Did patient's last pregnancy result in a miscarriage, stillbirth, a baby less than 5½ pounds, a baby born more than 3 weeks early, or a baby that stayed in the hospital after the patient went home? |
| 15. <input type="checkbox"/> | <input type="checkbox"/> | | 15. Does patient have any illness that requires continuing medical care? Specify illness: _____ |

14Y (1)

15Y (1)

Name and Title of Health Care Provider: _____		Provider's ID: _____	Provider's Phone Number: _____
Provider's Mailing Address: _____	City or Town: _____	Zip Code: _____	County Where Practice is Located: _____

<input type="checkbox"/> CHD Provider	<input type="checkbox"/> DOH Contracted Provider	<input type="checkbox"/> Private Provider	LMP (mo/day/yr) _____	EDD (mo/day/yr) _____	Trimester of pregnancy at 1st prenatal visit: _____
---------------------------------------	--	---	-----------------------	-----------------------	---

=2T (1)

2 or 3T T

Previous Obstetrical History: Enter the number of infants in each area. (Use zero for none.)
Term _____ Preterm _____ Abortion _____ Living _____ Low Birth Weight (less than 5½ pounds) _____

Healthy Start Screening Score _____	CHECK ONE <input type="checkbox"/> Referred to Healthy Start based on score. <input type="checkbox"/> Referred to Healthy Start based on factors other than score. Specify: _____ <input type="checkbox"/> Not referred to Healthy Start or Patient declined Healthy Start.
-------------------------------------	---

I have explained the Healthy Start program, and if screened, the patient's screening score.

Provider's/Interviewer's Signature and Title _____ Date (mo/day/yr) _____