Perinatal Risk Screening Tool

☐ **Medi-Cal** ☐ **Healthy Families** ☐ **AIM**

Name: _____ **ID#:** _____

Age: _____ **Phone #:** _____ **Service Area:** _____

Dates Called: _____ **Date Administered:** _____

Time Started: _____ **Time Stopped:**_____ **Total Time:** _____

Referral Source: _____ **Completed By:** _____

ACUITY LEVEL: _____

SURVEY NOT COMPLETED DUE TO:

☐ **Unable to reach member:**

☐ **Messages left x3, No call back**

☐ **No phone, No record of member at PCP office, No OB information**

☐ **Member refused due to:**

☐ **Member no longer pregnant.**

EDUCATION MATERIAL REQUESTED:

☐ **No** ☐ **Yes** ☐ **Education Dept. Notified**

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
1. When is your baby due?	_____/_____/_____ MM/DD/YY			
2. Who are you seeing for your pregnancy? Telephone:	**(_____)_____-_____**			
3. When was your first doctor's visit for this pregnancy? a) How many times have you seen your doctor since your first visit? b) When is your next appointment? c) How many appointments have you missed? d) Is there any reason you have problems keeping your appointment? If yes, what is the reason?	___/_____/_____ MM/DD/YY _____/_____/_____ MM/DD/YY	☐ **< 2** ☐ **N**	☐ **≥ 2** ☐ **Y**	

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
4. How many times have you been pregnant? a) How many children do you have? • What are their ages? b) Have you lost or terminated any pregnancies? • How far along were you? c) Have you had any pregnancies that you delivered more than one baby? d) For this pregnancy, do you think you're carrying more than one baby?	**Loss (SAB)** **Terminated (TAB)**	☐ **< 5** ☐ **< 2** ☐ **< 4** ☐ **N** ☐ **N**	☐ **≥ 5** ☐ **≥ 2** ☐ **≥ 4** ☐ **Y** ☐ **Y**	**Notify CM if pregnancies less than ONE year apart.** **If YES, how many losses?** **If YES, how many terminations?**
5. Were any of your babies born early (before 37 weeks)? If yes, why? • Were you ever treated for or hospitalized for preterm labor? • Have any of your babies needed to stay in the hospital after you went home? If yes, why?		☐ **N** ☐ **N** ☐ **N**	☐ **Y** ☐ **Y** ☐ **Y**	

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
6. Have you had any problems with previous pregnancies? Ex: a) Diabetes b) Excessive vomiting requiring intravenous hydration c) High blood pressure d) Bleeding after 12 weeks e) Other		☐ N ☐ N ☐ N ☐ N ☐ N	☐ Y ☐ Y ☐ Y ☐ Y ☐ Y	**A YES to any condition is considered high risk.**
7. How many of your babies were born by vaginal delivery? a) How many were born by C-Section? b) What type of delivery are you planning for this baby?	☐ Vaginal ☐ C-Section	☐ < 2	☐ ≥ 2	
8. Where are you planning to deliver your baby?	☐ Hospital ☐ Birthing Center ☐ Home			**Confirm use of a contracted facility at the end of the call and forward to CM if using non-contracted facility.**

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
9. Did you have any existing health problems prior to this pregnancy? Ex: a) Diabetes b) High Blood Pressure c) Asthma d) Kidney Disease e) Heart Disease f) Frequent Bladder Infections g) AIDS or HIV Infection h) Sexually Transmitted Diseases i) Surgery of the Uterus j) Other		N N N N N N N N N N	Y Y Y Y Y Y Y Y Y Y	**A YES to any condition is considered HIGH RISK.**
10. Have you ever had any problems with depression, anxiety disorders or other mental illness?		N	Y	
11. Have you had any problems or been hospitalized during this pregnancy? Ex: a) Diabetes b) Excessive vomiting requiring intravenous hydration c) High blood pressure d) Bleeding after 12 weeks e) Other		N N N N N N	Y Y Y Y Y Y	**A YES to any condition is considered HIGH RISK.**

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
12. Is there any family history of babies with physical or mental problems?		☐ N	☐ Y	
13. We need to know if you are taking any other medications:				
a) Please tell us what medication(s) are recommended or prescribed by your doctor including PNV, Folic Acid, and Iron?	☐ NONE	☐ N	☐ Y	
b) Please tell us what over-the-counter drugs are you taking, such as Tylenol, Aspirin, sleeping aids, etc.?	☐ NONE	☐ N	☐ Y	
c) Herbal remedies?	☐ NONE	☐ N	☐ Y	
14. During the past year, have you used any tobacco products?		☐ N	☐ Y	
a) If yes, and you used cigarettes how many packs do you smoke per day?				
b) If you stopped smoking, when did you stop?				
c) Does anyone smoke in your house?	☐ Y ☐ N If YES, see comments			If anyone smokes at home, encourage smoking cessation or smoking outside away from baby.

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
15. In the past year how many alcoholic beverages did you average in a week? a) If yes, when was your last drink? b) If you do not drink, when did you stop?		☐ N	☐ Y	**Any number is considered HIGH RISK.**
16. Have you used recreational drugs in the last year? a) If no, when did you stop? b) If yes, what are you using? c) How often do you use it/them?		☐ N	☐ Y	**Examples: Cocaine, Marijuana, Ecstasy, and Heroin.**
17. Have you been referred to Women, Infants & Children (WIC)?	☐ Y ☐ N			**If NO, instruct to contact local WIC office.**
18. Do you feel you are eating a healthy diet for you and your baby? • If no, why?		☐ Y	☐ N	A healthy diet includes three meals a day with balanced amounts of fish and meats, fruits and vegetables as well as grains or rice.

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
19. How are you planning to feed your baby?	☐ Breast ☐ Bottle ☐ Both			
20. Pregnancy can be a difficult time. Do you feel you have a good support system available from family or friends? • Do you live with baby's father? • Parents • Other adults	(Check ALL that apply) ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N	☐ **Y**	☐ **N**	
21. Do you have any concerns about your safety or the safety of your baby? • If yes why?		☐ **N**	☐ **Y**	
22. Do you have any other concerns? • If yes, what are they?		☐ **N**	☐ **Y**	

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
23. Are you receiving Comprehensive Perinatal Services Program (CPSP)? a) Was this offered? b) If not offered, would you like to receive CPSP services?	☐ Y ☐ N ☐ Y ☐ N	☐ Y	☐ N	**Medi-Cal Only. Do not rate for AIM or HF.**
24. Have you taken any classes related to pregnancy or child rearing? If YES, what have you taken?	☐ If NO, suggest the following: ☐ Breast Feeding ☐ Childbirth ☐ C/S Birth Class ☐ Infant Child Resuscitation ☐ Parenting ☐ Refresher Birth Class ☐ Sibling **FOR AIM MEMBERS:** ☐ Early Pregnancy Class			**For AIM, refer to Car Seat Program.**
25. Do you have a car seat for this baby?		☐ Y	☐ N	
26. Would you like our Health Education department to mail you information on pregnancy or other related health issues?	☐ Y ☐ N			**For Medi-Cal only.**

GUIDELINES TO CARE MANAGEMENT SCORING
(To be completed by the Perinatal Care Manager only.)

Risk Acuity Score: _____ R.N.: _____
(0 – 3)

Date: _____

Acuity Scoring	Category	Desk Top Reference
0	Low Risk	
1	Low/High Risk	
2	Moderate/High Risk	
3	High/High Risk	

CM Notes: